

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED		Month	Day	Year	2b. HOUR pm
Alvin		Adams			3		28	19	69	9:30
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		IF UNDER 24 HRS MIN	
M	Negro	1-21-58		11 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				Prince George				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale		Leland Hosp			STUDENT			NONE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md.		Prince George		College Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8003 48th Ave.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
JOSEPH		ADAMS		CATHERINE						?
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS						
NO				MRS CATHERINE ADAMS (MOTHER)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 8147 DUE TO, OR AS A CONSEQUENCE OF Transection of spinal cord at C2-C3 (b) Fracture dislocation of cervical vertebrae DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
										2 hrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 7:35 pm 3 29 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) Pedestrian struck by car.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street		21f. LOCATION Street or R.F.D. No. City or Town County State Navahoe St., College Park, P.G. Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED						
John Kehoe, M.D., Riverdale				3-30-69						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		4-3-69		MT ZION CEMETERY		BACONTOWN, PR GRGS, MD				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
ROBERT L. SNOWDEN		ROCKVILLE, MD		APR 3 1969		Charles Judge				

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APR 9 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04287					04279				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last					Month Day Year			HOURS MIN.	
Glenn Adkins					March 27, 1969			8:10 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		Cau		22 Mar 1926		43 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Va		United States		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Camp Springs, Maryland			Malcolm Grow			Retired		Marines	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
DC Md.			Prince Georges			Wash., D.C.		5416 Marlboro Pike	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
John H. Adkins					Sarah E. Plumley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) Yes, no, or (unknown)					16b. SOCIAL SECURITY NO.		17. INFORMANT Address		
Retired 1966							Marcella Adkins Same as item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophageal variceal hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholic Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Alcoholism</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1969</u> , to <u>March 27, 1969</u> , that (I) (we) last saw the deceased alive on <u>27 March 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Arnold Klipstein M.D.</u> DEGREE <u>MD</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>27 March</u>		
22d. PHYSICIAN'S NAME (Type) <u>ARNOLD KLIPSTEIN, CAPT USAF MC</u>					22e. ADDRESS <u>Malcolm Grow USAF Hosp Andrews AFB, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		4/1/69		Arlington National		Arlington, Va.			
24. FUNERAL DIRECTOR <u>Robert E. Wilhelm Funeral Home</u>					25a. RECEIVED BY REGISTRAR <u>APR 1 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		
4308 Suitland Rd., S.E., Suitland, Md., 20023									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A M
Edith			C.		Ali	March 13 1969			3:35
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		9/23/1909		39		YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa.		U.S.A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Glenn Dale			Glenn Dale Hospital			Dietary Services		---	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
47-1231 Eads St. N.E.			Wash., D.C.					4231 Eads St., N. E.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Boyce --- Sullivan			Reuperia -- White						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			578-28-8418			Decedent			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). Epidermoid carcinoma of the anus with PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>widespread metastases, treated by abdominal -</u> 7 months 1726 DUE TO, OR AS A CONSEQUENCE OF <u>perineal resection, 8/15/68</u> Conditions, if any, which gave rise to immediate cause (a), (b), (c) stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that the this hospital) attended the deceased from <u>10/21/</u> , 19 <u>68</u> , to <u>3/13/</u> , 19 <u>69</u> , that we (we) last saw the deceased alive on <u>3/13/</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Moe Weiss</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/13/1969		
22d. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.					22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland				
23a. (BURIAL) CREMATION, REMOVAL (Specify)		23b. DATE 3-19-69		23c. NAME OF CEMETERY OR CREMATORY Harmony Park		23d. LOCATION (City or Town) (County) (State) Landover Md			
24. FUNERAL DIRECTOR Rollins F.H. 4339 Hunt Pl. Wash. DC					25a. REC'D BY REGISTRAR DATE MAR 20 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

00322

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

February 1, 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours very truly,
J. B. H. [Signature]

Enclosed for you are two copies of a report of the [Name] [Title] [Department] [Date] [Page] [Page]

which you will find of interest.

I am, Sir, very respectfully,
Yours very truly,
J. B. H. [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04289										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04281																			
Item 6 Film 410 3/17/69 kk										CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or print) First Middle Last Marcus H. Armistead										2a. DATE OF DEATH Month Day Year 3/9/69										2b. HOUR P M 5:10 P M																			
3. SEX Male					4. RACE White					5. DATE OF BIRTH 03/19/97					6. AGE (In years last birthday) 71 1/2 YRS.					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN																			
7a. BIRTHPLACE (State or foreign country) Florida					7b. CITIZEN OF WHAT COUNTRY? U S A					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH Prince George's County Md.																								
10. CITY OR TOWN OF DEATH Cheverly					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Prince George's					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Welder					12b. KIND OF BUSINESS OR INDUSTRY Retired																								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland					13b. COUNTY Prince Geo.					13c. CITY OR TOWN New Carrollton					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER 7600 Fountbeau Drive																			
14. FATHER'S NAME First Middle Last Lat Armistead					15. MOTHER'S MAIDEN NAME First Middle Last ? ? ?																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. 577-20-5665					17. INFORMANT Alma W Armistead										Address New Carrollton, Md.																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchogenic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>6 mos</u>																								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Broncho pneumonia</u>																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <u>June, 1963</u> to <u>3/9, 1969</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>3/9, 1969</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> did <u>(did not)</u> view the body after death.																																							
22b. SIGNATURE <u>Norman D. Comeau MD</u>										DEGREE PHYS.										MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED <u>3/9/69</u>									
22d. PHYSICIAN'S NAME (Type) <u>NORMAN D. COMEAU</u>										22e. ADDRESS <u>3505 PERRY ST MT Rainier Md</u>																													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE <u>Mar 13, 1969</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>										23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u>									
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>										ADDRESS <u>Hyattsville, Md.</u>										25a. REC'D BY REGISTRAR DATE <u>MAR 13 1969</u>										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>									

04290

CERTIFICATE OF DEATH

04282

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR P	
George F. Aufrecht, Sr.						March 22, 1969			2:40 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Male		White		8/8/1908		60 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
D.C.		U.S.A.				Prince George's				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. General Hosp.			Retired			U.S. Govt.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13a. STREET AND NUMBER	
Maryland			Prince Georges		Cheverly				6413 Kilmer Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Carl G. Aufrecht			Clara unk							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, on, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
No			None			578268612 George F. Aufrecht Jr. Same as above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic bronchitis, emphysema</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic bronchial irritation</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 wks years years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>atherosclerotic heart disease with infarct and failure</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>2-19, 1969</i> to <i>3-22, 1969</i> , that (I) (we) last saw the deceased alive on <i>3-22, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, or other final disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/25/1969		Fort Lincoln Cemetery		Colmar Manor, Maryland				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Nalley's Funeral Home Mt. Rainier, Md.					MAR 26 1969		<i>John Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

02518

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TO HOSPITAL OR ATTENDING PHYSICIAN: The now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) LEONARD O. BALDWIN			2a. DATE OF DEATH Month March Day 29 Year 1969			2b. HOUR 9:45 P.M.				
3. SEX MALE		4. RACE White		5. DATE OF BIRTH June 3, 1903		6. AGE (in years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0		
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md				
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Worker		12b. KIND OF BUSINESS OR INDUSTRY Buildings		
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) STATE MD			13b. COUNTY P.G.		13c. CITY OR TOWN HT. PRINCE		13d. INSIDE CITY, J.M.T.S? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3805 37th ST.	
14. FATHER'S NAME First Andrew J. Middle Baldwin Last Baldwin			15. MOTHER'S M.A.D.E.N. NAME First Elizabeth F. Middle Trouton Last Trouton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, per (unknown) No			16b. SOCIAL SECURITY NO 217-32-1517		17. INFORMANT Address Edna M. Baldwin Mt Rainier Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 3-26, 1969 to 3-27, 1969 , that (I) (we) last saw the deceased alive on 3-26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Donald C. Edgren M.D.			DEGREE MD			ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN			22e. ADDRESS 6201 Mountbelle Rd. College Park, Maryland							
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 3/29/69		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.			ADDRESS			25a. REC'D BY REGISTRAR APR 1 1969		25b. REGISTRAR'S SIGNATURE W. L. ...		



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04292

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04284

1. DECEASED NAME (Type or Print) Della Lucille		First		Middle		Last Ball		2a. DATE KNOWN OF EST. DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 3-3-69 19 69			2b. HOUR 00am	
3. SEX Female	4. RACE White	5. DATE OF BIRTH 9-2-1926	6. AGE (In years last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month 3 Day 3 Year 69 19 69			2a. HOUR 0am	
7a. BIRTHPLACE (State or foreign country) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's						
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Draftsman			12b. KIND OF BUSINESS OR INDUSTRY Plan. Comm.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 8407 Irvington Avenue		
14. FATHER'S NAME Glenn Koehler				First		Middle		Last		15. MOTHER'S MAIDEN NAME Florence Wieland		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 391-22-2957		17. INFORMANT Edward D. Ball		ADDRESS 8407 Irvington Ave. Bethesda, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Rupture of spleen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HO: P.M. 10:45pm 3-2- 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Passenger of car involved in collision								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Metzerott Road and University Blvd., Prince George County, Maryland		21f. LOCATION Street or R.F.D. No		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE John Kehoe MD		EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MED CAL EXAMINER <input type="checkbox"/>		DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		
						ADDRESS (Street, city, town, or county) Prince Georges Co.		22b. DATE SIGNED 3-4-69				
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 3-6-69		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City or Town) Orchard Park		(County) New York		(State)		
24. FUNERAL DIRECTOR Robert A. Humphrey		ADDRESS 7537 Wisconsin		25a. REC'D BY REGISTRAR MAR 6 1969		25b. REGISTRAR'S SIGNATURE William J. Jones						

1510

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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04293		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04285	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or Print)		First		Middle		Last	
Edward						Ball, Jr.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
Male	White	7-5-1926		42 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
New York		U.S.A.				Prince George's Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Riverdale		Ireland Memorial Hospital				Planner	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Montgomery		Bethesda		8407 Irvington Avenue	
14. FATHER'S NAME		First		Middle		Last	
Edward						Ball, Sr.	
15. MOTHER'S MAIDEN NAME		First		Middle		Last	
Josephine						Marshall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS	
Yes		W.W. 11		134-20-4697		Edward D. Ball, Bethesda, Md., Ave	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock							
DUE TO, OR AS A CONSEQUENCE OF Left hemothorax							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) and Aspiration of gastric contents							
DUE TO, OR AS A CONSEQUENCE OF (c) and fracture of left femur							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		10:45pm 3-2- 19 69		Driver of car involved in collision			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or RFD No City or Town County State			
		Metzerott Road and University Blvd.		Prince George County, Maryland			
22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
John Kehoe MD		Riverdale, Md.				3-4-69	
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		3-6-69		Woodlawn Cemetery		Orchard Park, New York	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Humphrey				7557-21st Ave		MAR 6 1969	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04294

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04286

1 DECEASED-NAME (Type or print) First Middle Last Lewis W. Ball		2a DATE OF DEATH Month Day Year March 29, 1969		2b. HOUR A 11:45M
3 SEX Male	4 RACE Colored	5. DATE OF BIRTH 12/23/89	6 AGE (In years last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Washington D.C.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George's Md	
10 CITY OR TOWN OF DEATH Cheverly	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b COUNTY Prince George's	13c CITY OR TOWN Fairmont Hts.	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 6107 Jay St.
14. FATHER'S NAME First Middle Last UNKNOWN		15 MOTHER'S MAIDEN NAME First Middle Last UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) (If yes give war or dates of service) No		16b SOCIAL SECURITY NO. 22-2225626	17 INFORMANT Address Miss ELLA Ball - 737-61 Ave	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 1978 IMMEDIATE CAUSE (a) Adenocarcinoma of the Liver DUE TO, OR AS A CONSEQUENCE OF (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) Loss. Mass. Age & Shock. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)	21f LOCATION Street or R.F.D. No	City or Town	County State
22a. I certify that (x) (this hospital) attended the deceased from 3/12 , 19 69 , to Mar. 29 , 19 69 , that (x) (we) lost saw the deceased alive on Mar. 29 , 19 69 , and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above (x) (we) (did) (and not) view the body after death.				
22b SIGNATURE [Signature]		DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) Dr. S.V. Nair, M.D.		22e ADDRESS Prince George Gen. Hospital, Cheverly, Md.		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE 4-4-69	23c NAME OF CEMETERY OR CREMATORY HARMONY MEM. PARK LONDON	23d LOCATION (City or Town) (County) (State)	MD.
24. FUNERAL DIRECTOR UNIVERSAL FUNERAL HOME 816 H ST N.E. WASH. D.C.		25a REC'D BY REGISTRAR APR 3 1969	25b REGISTRAR'S SIGNATURE [Signature]	

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04295

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04287

1. DECEASED NAME (Type or print) First Middle Last Harriet Sybia Baxter			2a. DATE OF DEATH Month Day Year March 16 1969			2b. HOUR 0350AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH Dec. 14, 1920		6. AGE (In years last birthday) 48 YRS.	
7a. BIRTHPLACE (State or foreign country) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Andrews AFB		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY Prince George's		13c. CITY OR TOWN Hillcrest Hts		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 5759 26th Ave S.E.		14. FATHER'S NAME First Middle Last PHILLIP P. EPSTEIN		15. MOTHER'S M.A.DEN NAME First Middle Last CECELIA SHERKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No		16b. SOCIAL SECURITY NO 035-16-7853		17. INFORMANT James C Baxter Husband		Address Same as No. 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMA OF OVARY WITH METASTASIS</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MOS.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION 27 FEB 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABDO. MASS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 69, to 16 MAR 1969, that (I) (we) last saw the deceased alive on 15 MAR 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard Flax MD		DEGREE MD		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 16 MAR 69	
22d. PHYSICIAN'S NAME (Type) RICHARD FLAX		22e. ADDRESS MALCOLM GROW USAF HOSP. ANDREWS AFB					
23a. BURIAL CREMATION, REMAINS BURIAL		23b. DATE 3-19-69		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATH CEM		23d. LOCATION (City or Town) (County) (State) FT MYER VA.	
24. FUNERAL DIRECTOR W.W. Chonkew		ADDRESS 1400 Chapin St		25a. REC'D BY REGISTRAR DATE 20 1969		25b. REGISTRAR'S SIGNATURE W. W. Chonkew	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

04296

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04288

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month	Day	Year	2b HOUR	
William H Benton Jr					3-7-69				193	25am	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	7 UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		
Male	White	6-29-1899		69 YRS	MONTHS		DAYS		Month	Day	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
West Va		U S A				Prince George's Md.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			2b. KIND OF BUSINESS OR INDUSTRY		
Cheverly				Prince George Hospital		Carpenter			Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		3c. CITY OR TOWN		13a. INSIDE CITY LIMITS?		13c. STREET AND NUMBER	
Maryland				Prince George's		Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		6009 Lafayette Avenue	
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
William H Benton sr				Nannie Gorden							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
no				220 09 7784		Sarah E Ronemus		Alexandria Va.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>											
2910 DUE TO, OR AS A CONSEQUENCE OF <u>And Delerium tremens</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
				19							
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				3-8-69			
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
Riverdale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial				March 11, 1969		Wenwood Cemetery		Washington D. C.			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.				DATE		13 1969	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

2-8-59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04297		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04289	
Item 5 Film 0411 4/14/69 kk		CERTIFICATE OF DEATH			
1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH
MARY		RUTH	BERGLING		Month 3 Day 31 Year 1969 12:41 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6. AGE (In years last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS
FEMALE	WHITE	1895 SEPT. 18, 1885		73 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH		
D.C. WASHINGTON	U.S.	PRINCE GEORGE			
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
CHEVERLY	PRINCE GEORGE GEN. HOSP.		NURSE	NURSING	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm'ssion) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY L.H. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	
MARYLAND	PRINCE GEORGE	LANHAM		8810 Crandall Road	
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last			
John Bergling		Lillian Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO	17 INFORMANT		Address
no		578 09 2525A	Mary Ruth Chambers		Lanham, Md.
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>					1 year
4123 DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart failure</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1968</u> , 19 <u> </u> , to <u>3/29</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/29/69</u> , 19 <u> </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		3/3/69	
Leon R. Levitsky		3408 R I ave., Mt. Rainier, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
Burial	April 2, 1969	Mt Olivet Cemetery	Washington D C		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
F. Gaseh's Sons		Hyattsville, Md.		APR 3 1969	Charles Judge



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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04298

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04290

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3-2-69 1912:13am		2b HOUR
Robert Walker Berthiaume							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 3 Day 2 Year 69 19 12:45am	2d HOUR
Male	White	20 Feb. 1930	39 YRS.				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH	
MASS		U. S. A				Prince George's Md.	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital		CARPENTER		SAME	
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Prince George's		Bowie		8510 Zug Road	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
ARMAND				BERTHIAUME	ALICE		TREMBLEY
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
YES		019 2V 8230		ARMAND BERTHIAUME (13RD.)			
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock							
DUE TO, OR AS A CONSEQUENCE OF Bullet wound of lung							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) and Transection of spinal cord							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		12:10am 3-2-1969		Shot during altercation			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State			
		Home		same as #13			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		22b DATE SIGNED	
						3-3-69	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		MAR. 6. 1969		Baltimore National		Baltimore Md	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE	
Tabara Turner		Hon. J. Arthur Walker 254 Curran St.		DATE 6 1969			

01012

1 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04299

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04291

1. DECEASED NAME (Type or print) RICHARD MILTON BOUGHER			2a. DATE OF DEATH MAR Month 17 Day 69 Year			2b. HOUR 4:50 P.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 28 Jun 30		6. AGE (In years birthday) 38 YRS.		
7a. BIRTHPLACE (State or foreign country) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE'S		
10. CITY OR TOWN OF DEATH ANDREWS AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last 24 hours) MALCOLM GROW USAF HOSP			12a. USUAL OCCUPATION (Kind of work done during last 24 hours) POLICE		
12b. KIND OF BUSINESS OR INDUSTRY RET			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND			13b. CITY OR TOWN CLINTON		
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d. STREET AND NUMBER 7804 PINWOOD DR					
14. FATHER'S NAME HARRY LOGAN BOUGHER			15. MOTHER'S MAIDEN NAME EDNA ORA HILL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES (If yes give year, month, date of service) 1948-68			16b. SOCIAL SECURITY NO 333224201		17. INFORMANT WIFE SAME AS ITEM #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 4 Hours								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION 17 Mar 69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aspiration (Tracheostomy)			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or RFD No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 Mar , 19 69 , to 17 Mar , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 17 Mar , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.								
22b. SIGNATURE Arnold Klipstein DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22c. DATE SIGNED 17 Mar 69		
22d. PHYSICIAN'S NAME (Typed) ARNOLD KLIPSTEIN, CAPT USAF MC						22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/21/69		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24. FUNERAL DIRECTOR Robert L. Wilhelm Funeral Home 4308 Suitland Road, S.E., Suitland, Md., 20022				25a. REC'D BY REG STRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles G. Gage		

1000



FOR STATE
HEALTH DEPT.

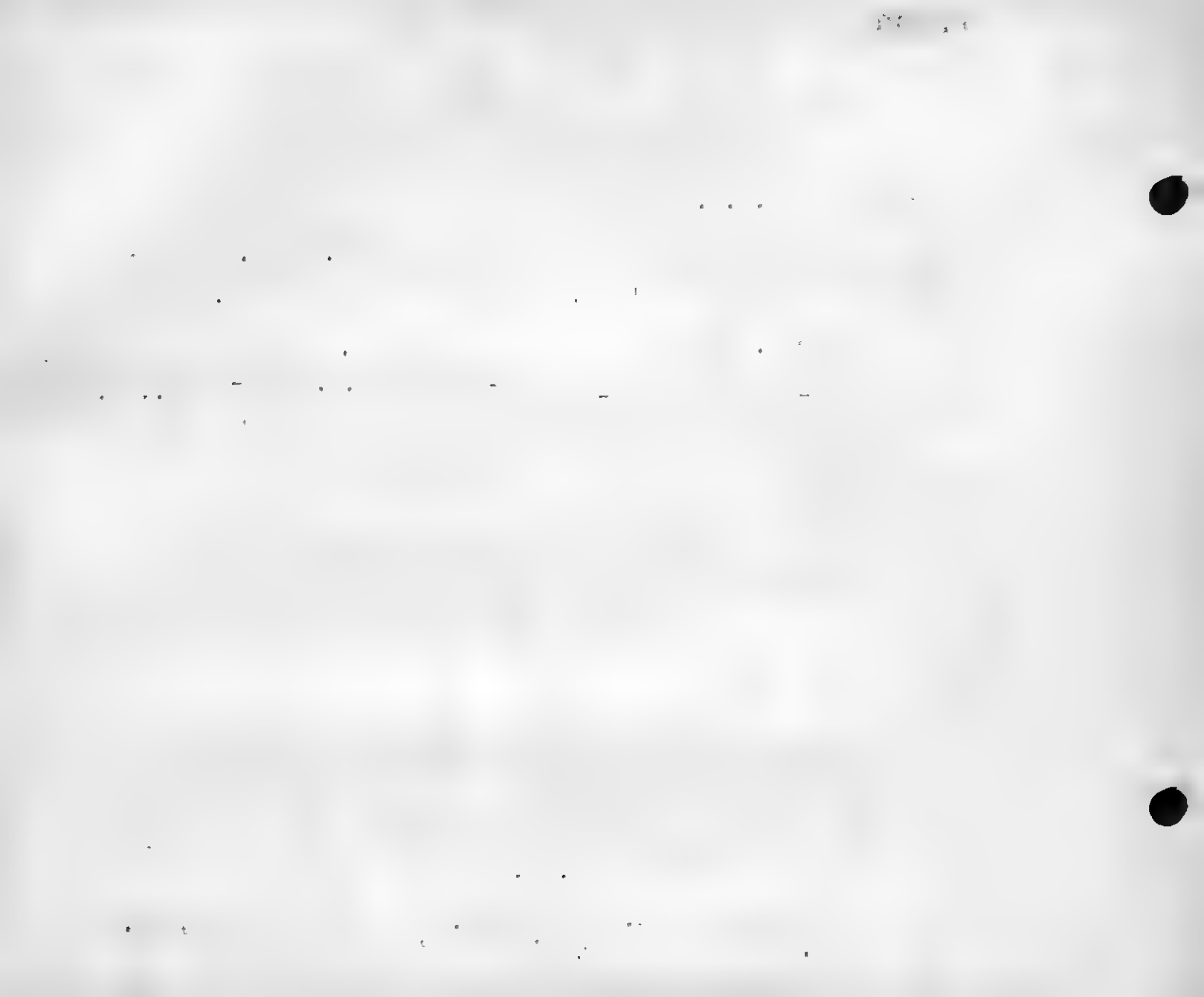
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item #4, Film #410 3/ MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04292

1 DECEASED-NAME (Type or Print)		First		Middle		BOWER Bowers		2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 3-9-69		2b HOUR 191:00am	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 10/26/1895		6 AGE (In years last birthday) 73 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month 3 Day 9 Year 69		2d HOUR 12:34pm	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.					
10 CITY OR TOWN OF DEATH Cheverly		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Ret. Hosp. Aid		12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Prince George's Mt.		13c CITY OR TOWN Rainier		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 4101 34th. Street			
14 FATHER'S NAME First Middle Last Walter J. Sweeney				15 MOTHER'S MAIDEN NAME First Middle Last Alice E. Howell							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		(If yes give war or dates of service) -		16b SOCIAL SECURITY NO 579-18-2940 A		17 INFORMANT Father E.D. Brown-		ADDRESS 34th & Rainier Ave., Mt. Rainier Md.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A M P M 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)		22b DATE SIGNED 3-10-69			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE 3/14/69		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d LOCATION (City or Town) Colmar Manor, Md.		(County)		(State)	
24 FUNERAL DIRECTOR Home Inc.		Nalley's Funeral		ADDRESS Mt. Rainier Maryland		REC'D BY REG STRAP DATE MAR 17 1969		25b REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>14</div> <div>04301</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>04293</div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
RITA S. BOYER						March 6, 1969			9:00 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN
Female		White		July 13, 1895			73 YRS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland		U. S. A.					Prince George Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			5601 Lockwood Road			Housewife			Own Home
3a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13a. COUNTY			3c. CITY OR TOWN			3d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md.			Prince George			Cheverly			5601 Lockwood Road
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Howard Sheriff			Margaret Scott						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
no			577 56 0995			Howard D. Fugitt 3205 Tremont Avenue Cheverly, Md.			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Multiple sclerosis									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1950, 19, to 3-6-1969, that (I) (we) last saw the deceased alive on 3-6-69 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
John Kehoe				March 6, 1969					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
John Kehoe, M. D.				Riverdale Road Riverdale, Md.					
23a. BURIAL, CREMATION OR REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/10/69		Cedar Hill		Suitland P.G. Md.			
24. FUNERAL DIRECTOR				25a. RECORDING OFFICE				25b. RECORDING OFFICE SIGNATURE	
Francis Gasch's Sons Hyattsville, Maryland				MAR 10 1969				John Kehoe	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04302		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		04294	
Item 13 Film 3410 3/18/69 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last Melvin H Brightman			2a. DATE OF DEATH Month 03 Day 05 Year 69		2b. HOUR A.M. 4:45
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH 10/18/95		6 AGE (In years lost birthday) 73 YRS	7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (State or foreign country) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges Md.		
10 CITY OR TOWN OF DEATH Adelphi	11. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 1801-Metzerott Rd. Manor Care Adelphi	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Secretary		12b. KIND OF BUS. NESS OR IND. STRY. Dairy	
13a. USUA. RES DENCE (Where deceased admiss on) STATE Maryland	13b. COUNTY Prince Georges/Hyattsville	13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13d. STREET AND NUMBER 7012 Wake Forest Drive 6500-Riggs Road		
14 FATHER'S NAME First Middle Last Lewis M Brightman	15 MOTHER'S MAIDEN NAME First Middle Last Harriet Lamb		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W W I		
16b. SOCIAL SECURITY NO 037-01-6891		17 INFORMANT Manor Care Adelphi- 1801-Metzerott Rd. Adelphi, Maryland			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Inanition and Malnutrition DUE TO, OR AS A CONSEQUENCE OF Paralysis Agitans Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME EARN STREET FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 1968, to 3-5, 1969, that (I) (we) last saw the deceased alive on 3-4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald C. Edgren		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN		22e. ADDRESS 6201 Greenbelt Road Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVA. (Specify) Cremation	23b. DATE Mar 7, 1969	23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory		23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.	
24 FUNERAL DIRECTOR F. Gassh's Sons Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

04303

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04295

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF EST. DEATH			Month	Day	Year	2b HOUR			
Robert Lee Brown						x 3 1 19 69						3:00 am			
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			Month	Day	Year		
M	W	14 Feb 1913	38 YRS.					3 1 19 69					9:05 am		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH						
Georgia			USA						Prince George Md						
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY						
Cheverly			Prince George			Retired			Largest Hayes						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER			
Md			Prince George			Forestville			3 NO			7727 Penna Ave.,			
14 FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last				
UNKNOWN						UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS						
no						Barry Brown			7727 Pennsylvania Ave., S.E., Wash., D.C., 20023						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:												Heart failure		Min.	
IMMEDIATE CAUSE (a)												4123			
DUE TO, OR AS A CONSEQUENCE OF												Arteriosclerotic heart disease		over 2 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b)			
DUE TO, OR AS A CONSEQUENCE OF												(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
Diabetes mellitus over 2 yrs.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY?					
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				John Kehoe, M.D.,						22b. DATE SIGNED					
EXAMINER'S NAME (Type)				Riverdale						3-1-69					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)					
Burial				3/3/69		Washington National				Washington, D. C.					
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Robert F. Wilhelm Funeral Home				MAR 7 1969						John Kehoe					
4308 Suitland Rd., S.E., Washington, D.C. 20023				DATE											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04296	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print) George J Burkhardt						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3-9-69 1911		2b. HOUR 30pm			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-17-1909		6. AGE (in years last birthday) 58 59RS		7c. DATE PRONOUNCED DEAD 3 Month 9 Day 69 Year 19 11:55pm		2d. HOUR 11:55pm	
7a. BIRTHPLACE (State or foreign country) Wisconsin			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Riverdale			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Professor of Agriculture			12b. KIND OF BUSINESS OR INDUSTRY U of Md		
13a. JSUA. RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8304 Adelphi Road	
14. FATHER'S NAME First Middle Last Martin J Burkhardt						15. MOTHER'S MAIDEN NAME First Middle Last Louise Bast					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO 217 32 3150			17. INFORMANT Gladys M Burkhardt			ADDRESS Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 412? DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21e. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street city, town, or county)			22b. DATE SIGNED 3-10-69					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE March 11, 1969			23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR F. Gassh's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE MAR 13 1969			25b. REGISTRAR'S SIGNATURE Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

<div>04305</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>04297</div>													
1 DECEASED-NAME (Type or print)			First Elizabeth		Middle E.		Last Byrne		2a. DATE OF DEATH Month Day Year			2b. HOUR	
									March 21, 1969			7 ¹⁰ A M	
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years lost birthday)			7 IF UNDER 24 HRS.	
female			white			April 10, 1889			79 YRS			MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Pa			U S A						Prince George's			Md	
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY				
Hyattsville,			6007 43rd ave			Retired Nurse			Hospital				
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?			13e STREET AND NUMBER	
Md			Pro Georges			Hyattsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6007 43rs avenue	
14 FATHER'S NAME			First Thomas Duffy		Middle		Last		15 MOTHER'S MAIDEN NAME			First Ellen J Maher	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address				
No			213 48 5026			Mary E. Dempsey			Hyattsville, Md.				
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY.												24 hours	
IMMEDIATE CAUSE (a) Cerebral thrombosis													
DUE TO, OR AS A CONSEQUENCE OF												Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.													
(b) ARTERIOSCLEROSIS, general													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
Pyelonephritis, ; Cerebral Thrombosis + stroke (old, post-status)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from JAN 15, 1968, to MARCH 22 1969, that (I) (we) last saw the deceased alive on MARCH 21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			22c. DATE SIGNED			22d. ADDRESS							
John F. Brennan Jr. M.D.			MARCH 22 1969			3415 HAMILTON ST., HYATTSTVILLE, MD.							
22e. PHYSICIAN'S NAME (Type)			22f. ADDRESS										
John F. Brennan Jr			3415 HAMILTON ST., HYATTSTVILLE, MD.										
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Mar 25, 1969			Baltimore National Cemetery			Baltimore, Maryland.				
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons			Hyattsville, Md.			Mar 26 1969			Charles Judge				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04306

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04298

1 DECEASED-NAME (Type or print) John H. Carlisle			2a. DATE OF DEATH Month 3 Day 31 Year 1969			2b. HOUR 2:30AM			
3 SEX Male		4. RACE White		5. DATE OF BIRTH 7-17-1896		6 AGE (In years (last birthday)) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) U.S.A.-Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARR ED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if in institution admission) STATE Maryland		13b. COUNTY Pr. George		13c. CITY OR TOWN Mitchellville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 1614 Enterprise Rd.	
14 FATHER'S NAME First Middle Last Not available			15 MOTHER'S MAIDEN NAME First Middle Last Not available			(Phone) 262-0123 (Address) Mrs. Viola Emmons			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO 226-32-8678		17 INFORMANT Hospital Record		Address Mrs. Viola Emmons			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic Failure 185 X DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Carcinoma of Prostate								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized Arteriosclerosis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept , 1968, to 30 March , 1969, that (I) (we) last saw the deceased alive on 30 March 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thomas M. Hutchins M.D. DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 3-31-69			
22d. PHYSICIAN'S NAME (Type) Thomas M Hutchins				22e. ADDRESS 7315 Landover Rd. Hyattsville, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3-31-69		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) Berryville, Va.			
24. FUNERAL DIRECTOR T. Gasch's Son				ADDRESS 4739 Bullitt Hwy, Hyattsville		25a. REC'D BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04307									
04299									
Information taken from birth certificate									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <u>Baby/Boy/</u> <u>Celich</u> <u>'S'</u>			2a. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1969</u>			2b. HOUR <u>10:03PM</u>			
3. SEX <u>Male</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>March 16, 1969</u>		6. AGE (In years last birthday) YRS. <u>—</u>		IF UNDER 1 YEAR MONTHS <u>2</u> DAYS <u>—</u>	
7a. BIRTHPLACE (State or foreign country) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George's</u> Md.			
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince George's Gen. Hosp.</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>Prince George's</u>		13c. CITY OR TOWN <u>Landover</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>PO BOX 1353</u>	
14. FATHER'S NAME First <u>Richard</u> Middle <u>Celich</u> Last <u>Ann</u>			15. MOTHER'S MAIDEN NAME First <u>Loretta</u> Middle <u>Grady</u> Last <u>Grady</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Atalectasis of lungs</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Prematurity</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>March 16</u> , 19 <u>69</u> , to <u>March 18</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>March 18</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE <u>3-29-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pr. Geo. General Hospital</u>		23d. LOCATION (City or Town) (County) (State) <u>Cheverly, Prince George's, Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Administrator</u>				25a. REC'D BY REGISTRAR DATE <u>APR 3 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04308

CERTIFICATE OF DEATH

04300

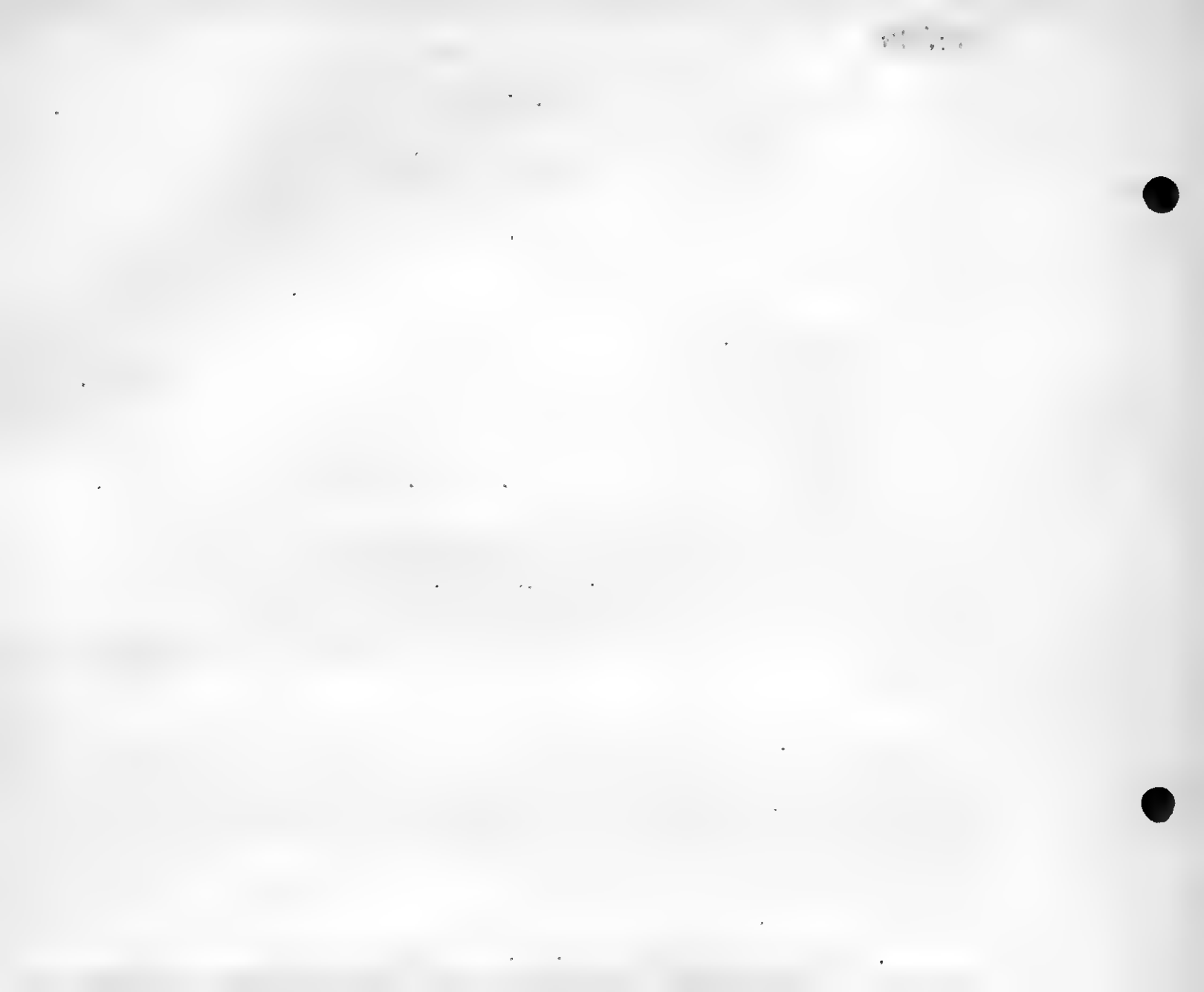
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month 10 Day 69 Year		2b. HOUR 10 1/2 A.M.	
Alice L. Chappell								
3 SEX	Female	4. RACE	White		5. DATE OF BIRTH	Sept. 25, 1906		6. AGE (In years last birthday) 62 YRS.
7a. BIRTHPLACE (State or foreign country)	Kansas	7b. CITIZEN OF WHAT COUNTRY?	U. S. A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Prince George		Md.
10 CITY OR TOWN OF DEATH	Marlowe Heights		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	4847 St. Barnabas Rd.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
						Clerk Typist		U.S.GOV.
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. since before admission) STATE	Md.	13b. COUNTY	P. G.	13c. CITY OR TOWN	Marlow Hgts.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 4847 St. Barnabas Rd.	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
Samuel E. Elder				Celia K. Murphy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown)	No	16b. SOCIAL SECURITY NO.	577-60-4798		17 INFORMANT	Address		
				Richard E. Chappell		7301 Lacona St. Berkshire Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Renal Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension 1st degree</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Jan 1966, to 3/10 1969, that (I) (we) last saw the deceased alive on 3/7 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Richard E. Chappell</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/10/69		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE Mar. 13, 1969		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Waldorf, Md.		
24. FUNERAL DIRECTOR Robert E. Wilhelm Fun. Home				ADDRESS 4308 Suitland Rd. Suitland Md.		25a. REC'D BY REGISTRAR MAR 17 1969		25b. REGISTRAR'S SIGNATURE <u>Priscilla Rudge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04309		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04301	
CERTIFICATE OF DEATH							
1 DECEASED NAME (Type or print)		First		Middle		Last	
George		M		Clinedinst			
3 SEX		4. RACE		5 DATE OF BIRTH		2a DATE OF DEATH	
male		white		July 12, 1912		Month Day Year March 26, 1969	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Va		U. S A				Prince George's Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Pro George's Hosp		Breakman		railroad	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Md		Pro George's Greenbelt				54 C Ridge Road	
14. FATHER'S NAME		First		Middle		Last	
Michael R		Clinedinst		Janette		Mantz	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <input checked="" type="checkbox"/> no		16b SOCIAL SECURITY NO		17 INFORMANT		Address	
		577 05 1918		Charlotte R Clinedinst		Greenbelt, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u>							5 mo
DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic glomerulonephritis</u>							6 yr
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes mellitus, Lipoma of the neck</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1964 to 26 Mar 1969, that (I) (we) last saw the deceased alive on 25 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE		22c DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			
<u>Ira N. Tablin</u>		3/27/69		Ira N. Tablin			
22e ADDRESS		22f ADDRESS		22g ADDRESS			
Silver Sp		Edinburg		Md			
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)	
Burial		Mar 30, 1969		Cedarwood Cemetery		Edinburg Va	
24 FUNERAL DIRECTOR		24b ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
F. Gasch's Sons		Hyattsville, Md.		APR 1 1969		<u>W. Chasley Judge</u>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

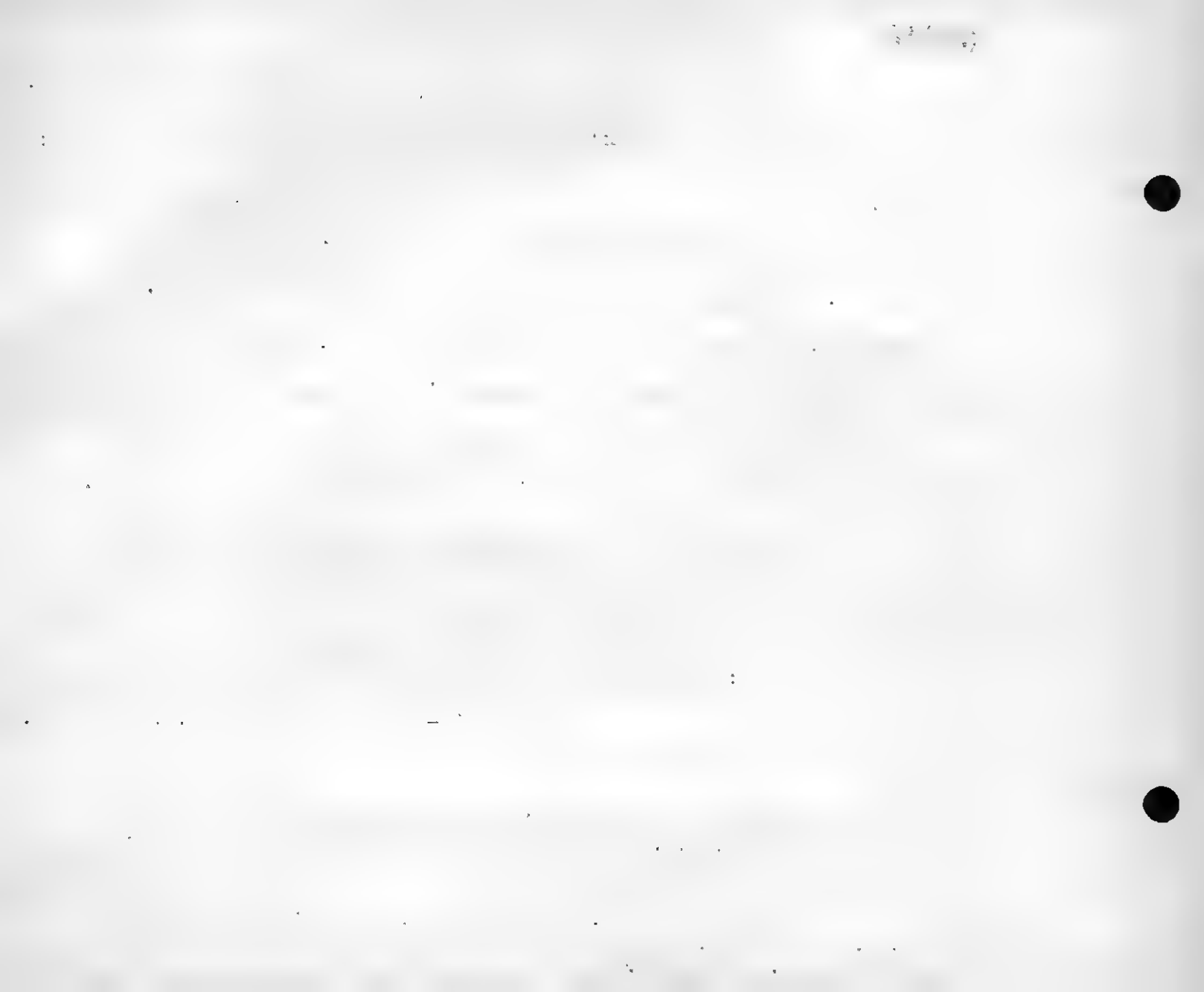
04310

04302

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-9 Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2c DATE KNOWN OF ESTI DEATH MATED		Month	Day	Year	2b HOUR P M	
Bruce		Edwin	Cooper		3 21 1969					5:40 P M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years Month Day YRS)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	7c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR P M	
M	W	16 dec 1956	34 12 YRS		3 21 1969					6:12 P M	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH						
Maryland		USA			Prince George		Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince Georges General		Student						
13a U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Md.			Prince George		Lanham				6605 96th Ave.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Charles L. Cooper						Barbara H. Cooper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			none			Charles L. Cooper, see blk# 13e					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) Skull fracture DUE TO, OR AS A CONSEQUENCE OF (c) Fall from tree APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5:40pm 3 21 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) Fell from tree						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Back yard		21f. LOCATION Street or R.F.D. No 6603 96th Ave		City or Town Lanham		County I.G.	State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion a death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 3-23-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial			March 24, 1969		Geo. Washington Cem.		Hyattsville, Maryland				
24. FUNERAL DIRECTOR Lanham F. H. Of Robert G. Beall					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
9013 Annapolis Rd. Lanham, Md.					MAR 26 1969						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04311

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04303

1. DECEASED-NAME (Type or print) Leon Howard Craft			2a. DATE OF DEATH March 18, 1969		2b. HOUR 9:05 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Nov. 14, 1911		6. AGE (In years last birthday) 57 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George		
10. CITY OR TOWN OF DEATH Cheverly	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Gen Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Operations Executive	12b. KIND OF BUSINESS OR INDUSTRY Trucking Co.	
13a. USUA. RESIDENCE (Where deceased lived, if institution residence before admission) STATE Maryland	13b. COUNTY Caroline	13c. CITY OR TOWN Federalburg	13d. INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Reliance Road	
14. FATHER'S NAME First Middle Last William H. Craft	15. MOTHER'S MAIDEN NAME First Middle Last Edna Willin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO 213-03-9696	17. INFORMANT Emma Craft Same Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a)

Ventricular Heart Stab.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Coronary Thrombosis & Acute myocardial infarct

DUE TO, OR AS A CONSEQUENCE OF

(c)

St. Hypohemoria

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (th's hospital) attended the deceased from Mar. 17, 1969, to Mar. 18, 1969, that (I) (we) last saw the deceased alive on Mar. 18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i>	DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED Mar. 18, 1969	
22d. PHYSICIAN'S NAME (Type) S.V. Nair M.D.	22e. ADDRESS Prince George Hosp Cheverly, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE March 22, 1969	23c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	23d. LOCATION (City or Town) (County) (State) Federalburg, Maryland
24. FUNERAL DIRECTOR J.S. Frampton & Son, Federalburg, Maryland	25a. REC'D BY REGISTRAR DATE MAR 24 1969	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04312

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04304

1. DECEASED-NAME (Type or print) Leonard S. Crandall			2a. DATE OF DEATH Month March , Day 16 , Year 1969		2b. HOUR PM 9:28
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH 9-26-15		6. AGE (In years lost birthday) 53 YRS.	7. UNDER 1 YEAR MONTHS 0 DAYS 0
7a. BIRTHPLACE (Store or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince Georges	
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) E. Leland Mem. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Conductor	12b. KIND OF BUSINESS OR INDUSTRY R.R.
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY P.G.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3102 Madison Place	
14. FATHER'S NAME First William Middle C. Last Crandall		15. MOTHER'S MAIDEN NAME First Florence Middle M. Last Shegogue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If unknown) WWII		16b. SOCIAL SECURITY NO 216-05-3711		17. INFORMANT H. Marie Crandall Address Same as above (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Myocardial Failure DUE TO, OR AS A CONSEQUENCE OF Coronary Thrombosis (b) Arterio-sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21f. LOCATION Street or R.F.D. No City or Town County State	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1955 , 19 Mar , 19 69 , that (I) (we) last saw the deceased alive on 3-16-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and) (d not) view the body after death.					
22b. SIGNATURE W.C. Etienne		22c. DATE SIGNED 3-16-69		22d. PHYSICIAN'S NAME (Type) W.C. Etienne	
22e. ADDRESS College Park, Md.		22f. ADDRESS College Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/19/69		23c. NAME OF CEMETERY OR CREMATORY Angel Hill Ceme.	
23d. LOCATION (City or Town) (County) (State) Hyattsville, Md.		23e. LOCATION (City or Town) (County) (State) Hyattsville, Md.			
24. FUNERAL DIRECTOR Francis Gasch's Sons		ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE MAR 19 1969	
25b. REGISTRAR'S SIGNATURE J. Charles Young					

jwb

VR 115
30M REV. 1-64



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18-22a Film 415 MARYLAND STATE DEPARTMENT OF HEALTH
7-31-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
04313 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04305

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month Day Year				2b HOUR	
Paul		Lorenzo		Crisp		3-17-69 1911				00 PM			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year				2d HOUR	
Male	White	11-16-1911	57 YRS					3 18 69				12:35 PM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Md		U S A		Prince George's						Md			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b KIND OF BUSINESS OR INDUSTRY	
College Park				9122 Balt. Ave. Hillcrest Hotel				Mechanic				Self	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland						Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>		1846 N. Gay Street			
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME			
Unknown										Unknown			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT				ADDRESS			
no				265 03 4292		Donald Paul Crisp				Glenn Dale, Md			
18. CAUSE OF DEATH (Enter on any one cause per line for (a) (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hepatic failure</u>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) <u>Cirrhosis of liver</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
MEDICAL CERTIFICATION													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
				19 P.M.									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				3-19-69					
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Riverdale, Md.				ADDRESS (Street, city, town, or county)									
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial				Mar 21, 1969		Ft Lincoln Cemetery				Colmar Manor Pro Geo Md.			
24 FUNERAL DIRECTOR ADDRESS													
F. Gasch's Sons Hyattsville, Md.													
25a REC'D BY REGISTRAR								25b REGISTRAR'S SIGNATURE					
DATE MAR 24 1969													



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04314										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04306									
1. DECEASED NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
Janie ALVEY Cross										3 Month 28 Day 69 Year										4:15 AM									
3. SEX Female										4. RACE white										5. DATE OF BIRTH 3/17/1900									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
10. CITY OR TOWN OF DEATH Clinton Md										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md										13b. COUNTY Prince George Brandywine										13c. STREET AND NUMBER R. 3 Box 211									
14. FATHER'S NAME First Middle Last Walter Cross										15. MOTHER'S MAIDEN NAME First Middle Last Carrie Cantor																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No										16b. SOCIAL SECURITY NO. 213-38-1703										17. INFORMANT Address Walter Cross (brother) R. 3 Box 211 Brandywine									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest																													
DUE TO, OR AS A CONSEQUENCE OF (b) Circulatory Collapse																													
DUE TO, OR AS A CONSEQUENCE OF (c) Carcinomatosis																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Carcinoma of Vagina & Uterus & metastases																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 3/18, 1969, to 3/28, 1969, that (I) (we) last saw the deceased alive on 3/27, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Alfred R. Lapin M.D.										22c. DATE SIGNED 3/28/69																			
22d. PHYSICIAN'S NAME (Type) ALFRED R. LAPIN, M.D.										22e. ADDRESS CLINTON, MD																			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 3-31-69										23c. NAME OF CEMETERY OR CREMATORY IMMANUEL CEMETERY									
23d. LOCATION (City or Town) (County) (State) BADEN, P.G., MD.																													
24. FUNERAL DIRECTOR H. H. Waldorf										25a. REGD BY REGISTRAR APR 1 1969										25b. REGISTRAR'S SIGNATURE Charles Judge									



04315

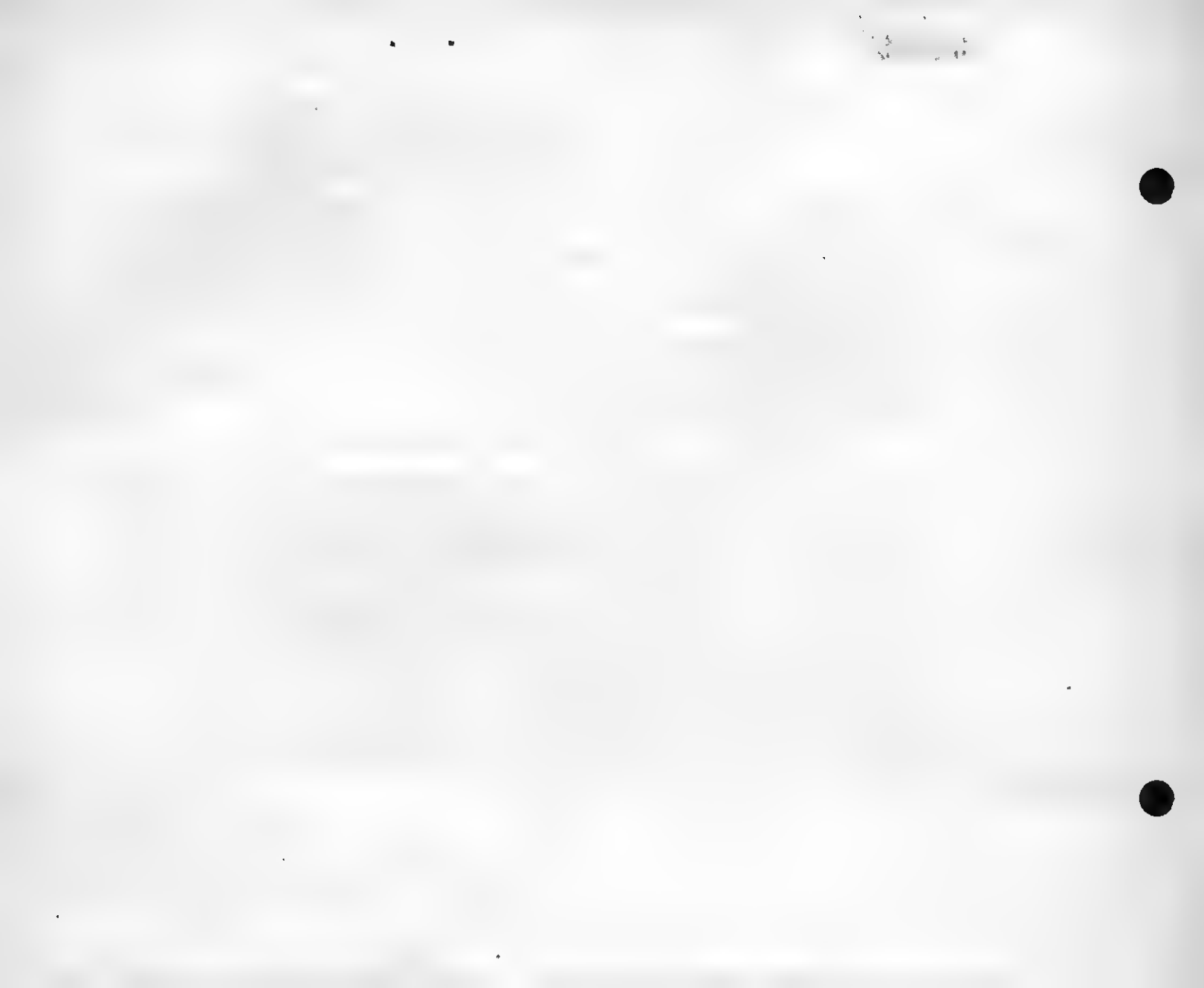
CERTIFICATE OF DEATH

04307

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
ERNEST WILMER CROSSON					Mar. 10, 69		8:45 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
M	CAUC		10-29-1893		75 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.
ALEX. VA.		USA		F. G.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
GREENBELT, MD.		GREENBELT CONV. CO.						
13a. US. AL. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md		Pro Geo co		New Carrollton		<input type="checkbox"/> YES <input type="checkbox"/> NO		7501 Tipton st
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Ernest E Crosson					Mary Bailey			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no				Mary E Crosson		New Carrollton, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u>								1 hr.
4109 DUE TO, OR AS A CONSEQUENCE OF								
(b) <u>peripheral vascular disease</u>								8 yrs
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or RFD No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 19, 32</u> , to <u>Mar 10, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 6, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
<u>E. B. Quayle M.D.</u>							3-10-69	
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS			
<u>E. B. Quayle M.D.</u>					<u>1822 Biltmore St NW Washington D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		March 13, 1969		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR	
F. Gasch's Sons					Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE	
							<u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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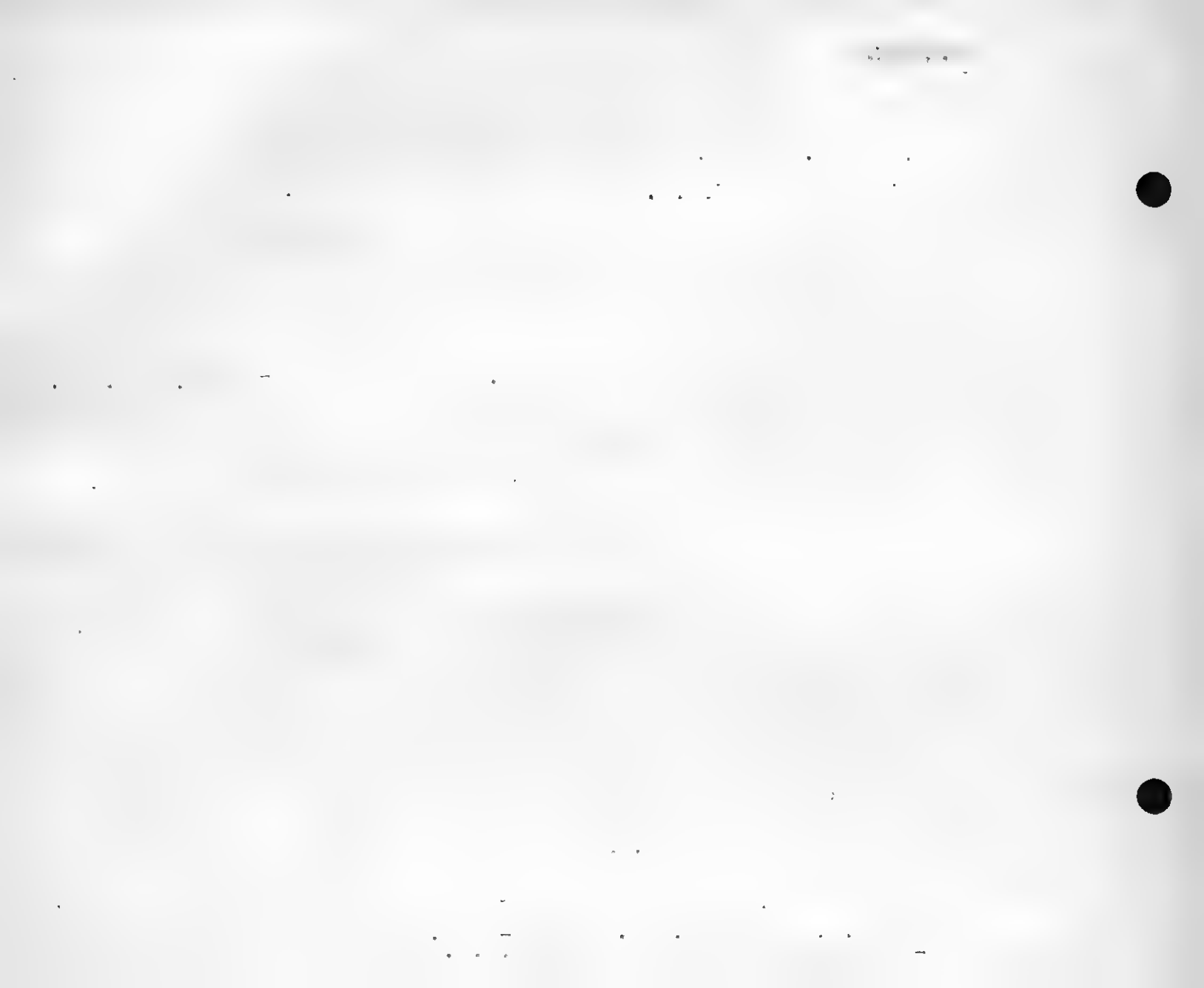


**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-1. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last Gloria Francis Crowley			2a DATE KNOWN OF DEATH Month Day Year 3 29 19 69			2b HOUR p M 2:50
3 SEX F	4 RACE W	5 DATE OF BIRTH 1 Jan., 1927	6 AGE (in years last birthday) 42 YRS	7 UNDER YEAR MONTHS DAYS 2 28	8 IF UNDER 24 HRS HOURS MIN. 28	2c DATE PRONOUNCED DEAD Month Day Year 3 29 19 69			2d HOUR p M 2:50
7a BIRTHPLACE (State or foreign country) Illinois		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George			Md
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b COUNTY Prince George		13c CITY OR TOWN District Heights		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 7800 Kipling Parkway	
14. FATHER'S NAME First Middle Last John Kopina			15. MOTHER'S MAIDEN NAME First Middle Last Frances Kopina ---			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <input checked="" type="checkbox"/>			
16b SOCIAL SECURITY NO no			17 INFORMANT (Husband) Mr. William Crowley - Dist. Hgts., Md.			ADDRESS 7800-Kipling Pk			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, N.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town or county)			22b DATE SIGNED 3-29-69			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Apr. 1/69		23c NAME OF CEMETERY OR CREMATORY -----		23d LOCATION (City or Town) (County) (State) Spring Valley, Illinois			
24 FUNERAL DIRECTOR M.W. Hysong Co. Inc. PER- Thomas M. Hysong			ADDRESS 1300-N St. NW Wash. D.C.		RECORDED BY REG. STRAR DATE APR 1 1969		25b REG. STRAR'S SIGNATURE		



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1

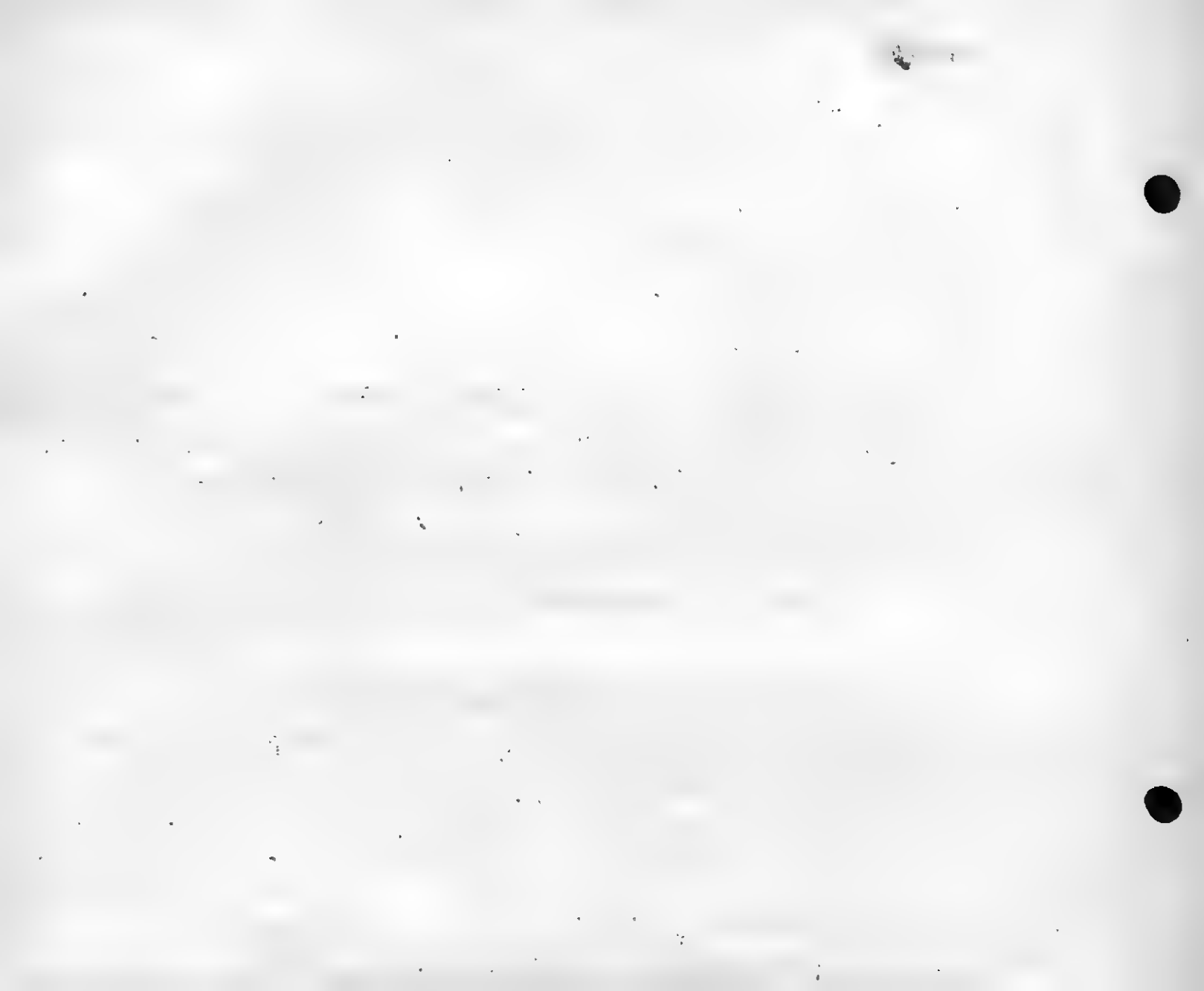
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04317

CERTIFICATE OF DEATH

04309

1. DECEASED-NAME (Type or print) Ann M Crump			2a. DATE OF DEATH Month March Day 29 Year 1969			2b. HOUR 7 A M	
3 SEX Female		4 RACE White		5. DATE OF BIRTH April 24 1901		6 AGE (In years last birthday) 57 YRS.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.	
10. CITY OR TOWN OF DEATH Bowie		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 12409 Seabury Lane		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H wife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 12409 Seabury Lane		14. FATHER'S NAME First John F. Middle O'Neill Last 		15. MOTHER'S MAIDEN NAME First Elizabeth Middle McKenna Last 			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address John R. Crump Same as 13 ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO, OR AS A CONSEQUENCE OF Metastatic Carcinoma liver, abdomen, bone + system (b) Carcinoma of Rectum DUE TO, OR AS A CONSEQUENCE OF (c) 							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 3 years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 69 , to 29 Mar , 19 69 , that (I) (we) lost saw the deceased alive on 28 Mar , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas G. Maloney M.D.				22c. DATE SIGNED 29 Mar 69		22d. PHYSICIAN'S NAME (Type) Thomas G. Maloney	
22e. ADDRESS 4814 71st Ave Landover Hills, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-1-1969		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l		23d. LOCATION (City or Town) (County) (State) Port Myer, Va	
24. FUNERAL DIRECTOR Robert A. Mattingly		ADDRESS 131 11th St. S.E. D.		25a. REC'D. BY REGISTRAR 6 APR 1 1969		25b. REGISTRAR'S SIGNATURE John R. Crump	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div>18 Film 412 5-2-68</div> <div>04318</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>04310</div>											
1. DECEASED-NAME (Type or Pr. nt)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Michael Allen D'Agnewica						<input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> 3-5-69 180:30am			<input type="checkbox"/> 30am <input type="checkbox"/> 30am		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR		
male	White	11-19-68	— YRS 3 14			Month 3 Day 5 Year 69 19 11 50am					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
WASHINGTON, DC		U.S.				Prince George's Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			NONE					
13a. USUAL RESIDENCE (Where deceased lived, if not tut on Residence before admission) STATE				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland				Prince George's Landover		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3421 Dodge Park Road #201			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
CARROLL D'AGNEWICA.			DOREEN HAMMOND								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS				
NO			NONE		CARROLL D'AGNEWICA.		SAME AS #13				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unknown</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>SDII</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTR. BUTING TO DEATH BUT NOT RELATED TO THE TERMAL DISEASE OR COND TION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNA. CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my apinian death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe MD		Riverdale, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MED CAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		3-6-69	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		3-7-1969		FORT LINCOLN CEMETERY		COLMAR MANOR, MARYLAND					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W.W. CHAMBERS, C.				RIVERDALE, MD.				DATE MAR 7 1969		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04319		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				04311	
Item: 3 Film 110 3/26/69 kk							
1. DECEASED NAME (Type or print) First Middle Last <u>ROBERT THOMAS DAVIS</u>			2a. DATE OF DEATH Month Day Year <u>3 6 69</u>			2b. HOUR M <u>11</u>	
3. SEX <u>Male</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>1/6/1892</u>		6. AGE (In years last birthday) <u>77</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>SC.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George</u> Md.	
10. CITY OR TOWN OF DEATH <u>Clinton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Pine View Gardens</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Minister</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Washington, D.C.</u>		13c. CITY OR TOWN <u>Clinton</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>410 Mt. SE Apt. 708</u>	
14. FATHER'S NAME First Middle Last <u>Robert DAVIS</u>			15. MOTHER'S MAIDEN NAME First Middle Last <u>Lance Anthony</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <u>261-28-5664</u>		17. INFORMANT Name Address <u>William Thomas 410 Mt. SE Apt. 708</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1 DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest due to myocardial infarction</u>							
441.2 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) <u>Caused by Coronary Arteriosclerosis</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>Coronary Arteriosclerosis</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Coronary Arteriosclerosis</u>							
19a. DATE OF OPERATION <u>2/1/69</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Myocardial Infarction</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1</u> , 19 <u>69</u> , to <u>5/6</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/1</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Robert R. Taylor</u>				22c. DATE SIGNED <u>3/6/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>HELENE R. LAMM</u>				22e. ADDRESS <u>CLINTON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3-12-69</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Woodlawn Cems.</u>		23d. LOCATION (City or Town) County State <u>Mayesville Washington SC</u>	
24. FUNERAL DIRECTOR <u>Hall Bros. (D.K.) 621 Fla. Ave.</u>				25a. REC'D BY REGISTRAR <u>NAR 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

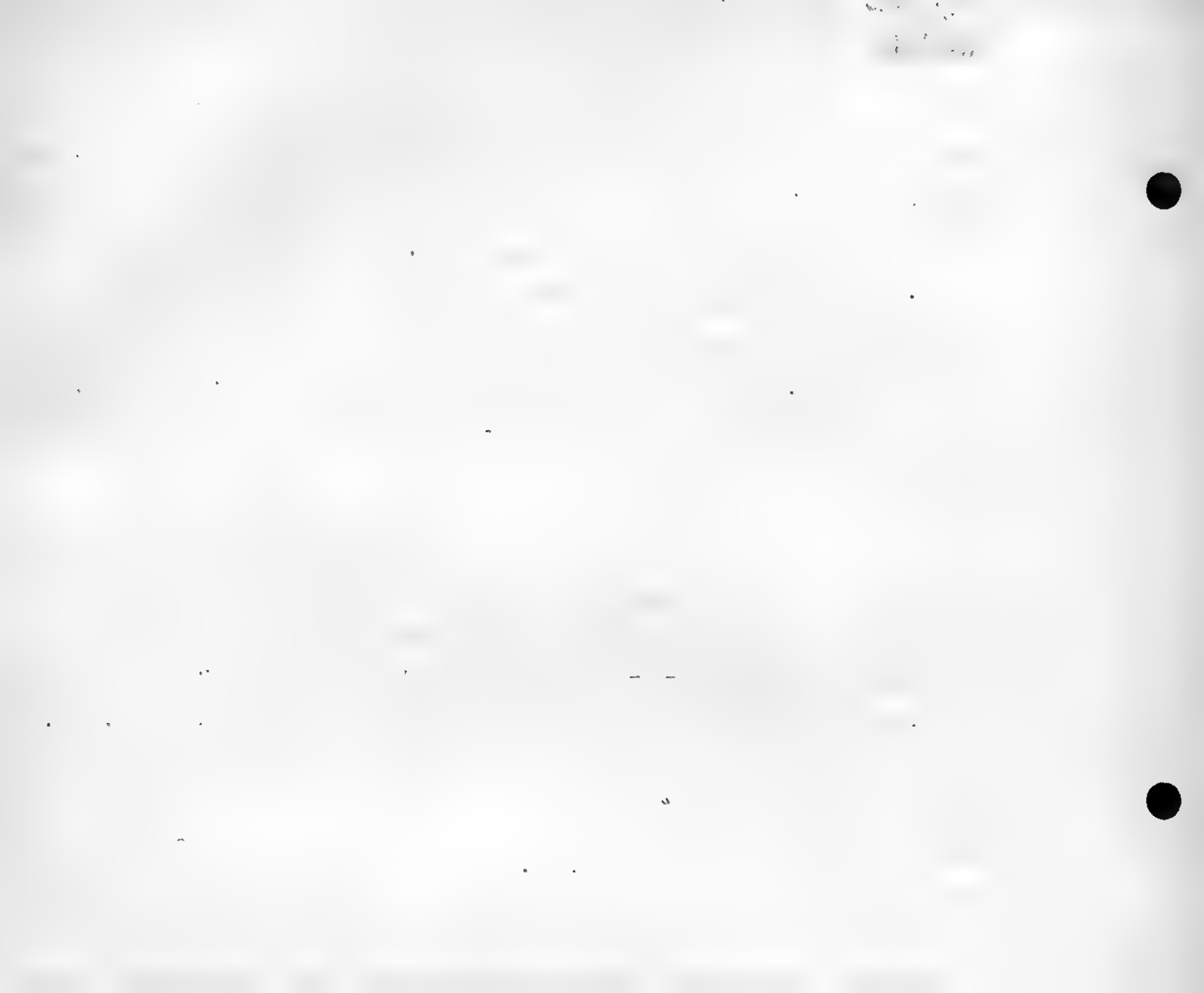
04320

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04312

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 3-14-69		2b HOUR 19 6:30pm	
James		Andrew		DeRovin							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR MONTHS	7 UNDER YEAR DAYS	7 UNDER YEAR HOURS	7 UNDER YEAR MIN	2c DATE PRONOUNCED DEAD Month 3 Day 14 Year 69		2d HOUR 19 6:37pm M	
Male	White	2-5-1947	22 YRS								
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
ESCANABA, MICH.		USA.				Prince George's				Md	
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Suitland		Andrews Air Force Base Hosp.		SGT		U.S. MARINE CORP					
13a. USUAL RESIDENCE (Where deceased admission), STATE		13b. I INSTITUTION Residence before		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Mich.		✓		Muskegon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3278 Black Creek Road			
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last	
ANDREW L DEROUIN								LUCILLE MARIE			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
YES		UNKNOWN		UNKNOWN		MARINE CORP RECORDS		ANDREWS AFB.			
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))		PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Burns 100% of body surface		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
17X		DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF							
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. 6:30pm 3-14- 1969		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		Burned in fuel truck explosion					
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No		City or Town		County		State	
		Andrews Air Force Base Hospital, Suitland, Prince George Co., Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED		3-15-69					
John Kehoe MD		Riverdale, Md.									
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
BURIAL		3-19-69				MUSKEGON				MICH.	
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
W.A. Chambers Co		1400 Chapin St NW		DATE		MAR 20 1969					

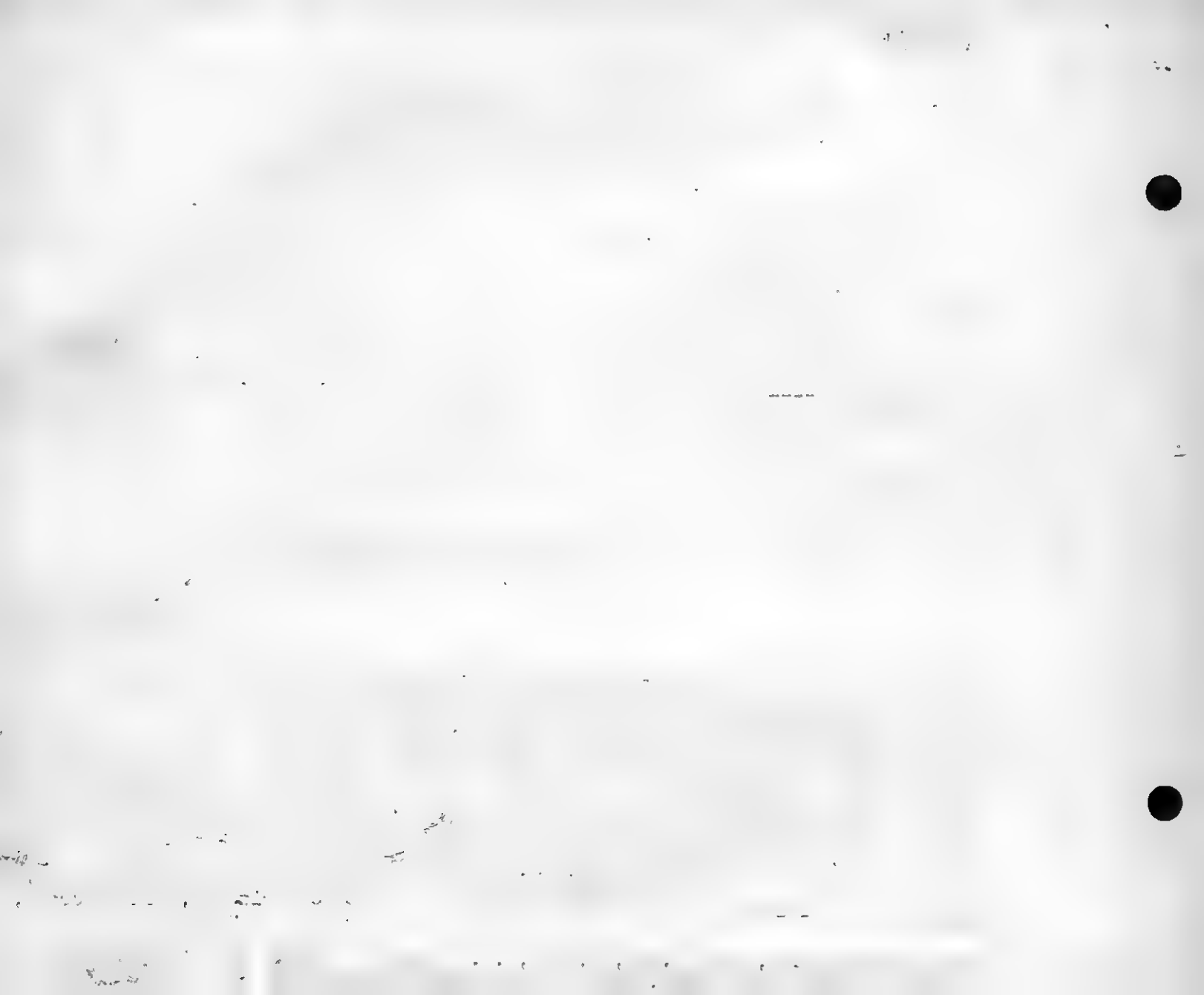


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
<div>04321</div> <div>04313</div>										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/>			Month Day Year	
John Baptista deVasconcellos						3-30-69			1969	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	Cauc	06-24-23	45 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	11:15	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Brazil		Brazil		W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George's Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Georges Gen. Hosp.			Physician			self-employed	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13e. STREET AND NUMBER	
Md.			Prince Georges Laurel			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			8809 Hunting Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Salomao deVasconcellos			Branca deCaryvalho							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS				
no			None			2400 Virginia Ave NW, Washington, DC				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute subdural hematoma</u>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b) _____										
DUE TO, OR AS A CONSEQUENCE OF										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			PM 3-27- 19 69			Fell at home				
21d. NATURE OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town	County State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			home			same as #13				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MED. CA. EXAMINER			22b. DATE SIGNED	
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						3-31-69	
John Kehoe MD			Rivendale, Md.			ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial/Transit			4-8-1969						Belo Horizonte, Minas Gerais, Brazil, South America	
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Joseph Gawler's Sons, 5130 Wis. Ave, NW, Wash, D.C.						DATE APR 7 1969		Charles Judge		
20016, USA										



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04314					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED NAME (Type or Print)			First Middle Last Takis George Dimopoulos			2a. DATE KNOWN OF DEATH			Month Day Year 3 14 19 69		2b. HOUR 1:15 am				
3. SEX M		4. RACE W		5. DATE OF BIRTH 29 May 1886		6. AGE (In years last birthday) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 3 14 19 69		2d. HOUR 2:00 am	
7a. BIRTHPLACE (State or foreign country) GREECE			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George						
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp.			12a. JSuA: OCCUPATION (Kind of work done during most of working life, even if retired) PROOF READER			12b. KIND OF BUSINESS OR INDUSTRY NEWSPAPER						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE N.Y.			13b. COUNTY Queens			13c. CITY OR TOWN NYC			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 3769 93rd St.			
14. FATHER'S NAME First Middle Last GEORGE - DIMOPOULLOS			15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 056-05-2736			17. INFORMANT ADDRESS THOMAS DIMOPOULLOS - CHEVERLY, MD.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 Heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min Yrs.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			John Kehoe, M.D., Riverdale			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED 3-15-69						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3-19-69			23c. NAME OF CEMETERY OR CREMATORY FLUSHING CEMETERY			23d. LOCATION (City or Town) (County) (State) FLUSHING QUEENS N.Y.						
24. FUNERAL DIRECTOR W.W. CHAMBERS			ADDRESS WASHINGTON, D.C.			25a. REC'D BY REGISTRAR DATE MAR 20 1969			25b. REGISTRAR'S SIGNATURE G. Chambers						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04323										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04315				
Item # 111111 4/2/69 kdk										CERTIFICATE OF DEATH														
1 DECEASED NAME (Type or print)					First Middle Last					2a. DATE OF DEATH					2b. HOUR									
George					E. Distin					March 24, 1969					5:57 PM									
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		IF UNDER 24 HRS. HOURS		IF UNDER 24 HRS. MIN								
Male		White		April 21, 1887			81 92 YRS																	
7a BIRTHPLACE (State or foreign country)					7b CITIZEN OF WHAT COUNTRY?					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH									
Custer Co., N.Y.					USA										Prince George's Md									
10. CITY OR TOWN OF DEATH					11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)					12b KIND OF BUSINESS OR INDUSTRY									
Cheverly					Prince George's Gen. Hosp.					Laborer														
13a USUA. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE					13b. COUNTY					13c CITY OR TOWN					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e STREET AND NUMBER				
MD					Prince George's					Hyattsville					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					5716 Sheridan Street.				
14. FATHER'S NAME					15 MOTHER'S MAIDEN NAME																			
Charles Edward Distin					Cecelia Beck																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b SOCIAL SECURITY NO					17 INFORMANT					Address									
					044 09 4294 A					Robert E. Distin					7102 Allison St. Landover Hill Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>															5 minutes									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																								
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarct</u>															10 minutes									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>															10 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)														
					HOUR A.M. Month Day Year P.M. 19																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION														
										Street or R.F.D. No. City or Town County State														
22a. I certify that (I) (this hospital) attended the deceased from <u>15 Nov. 1968</u> to <u>24 Nov. 1969</u> , that (I) (we) last saw the deceased alive on <u>20 Nov. 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE										DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED. D. RECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED				
Thomas G. Maloney, M.D.																				25 Nov 69				
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)									
Burial					3/28/1969					St. John's Cemetery					Adams Co., New Chester, Pa.									
24. FUNERAL DIRECTOR										ADDRESS					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Fred T.					MAR 28 1969					...				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

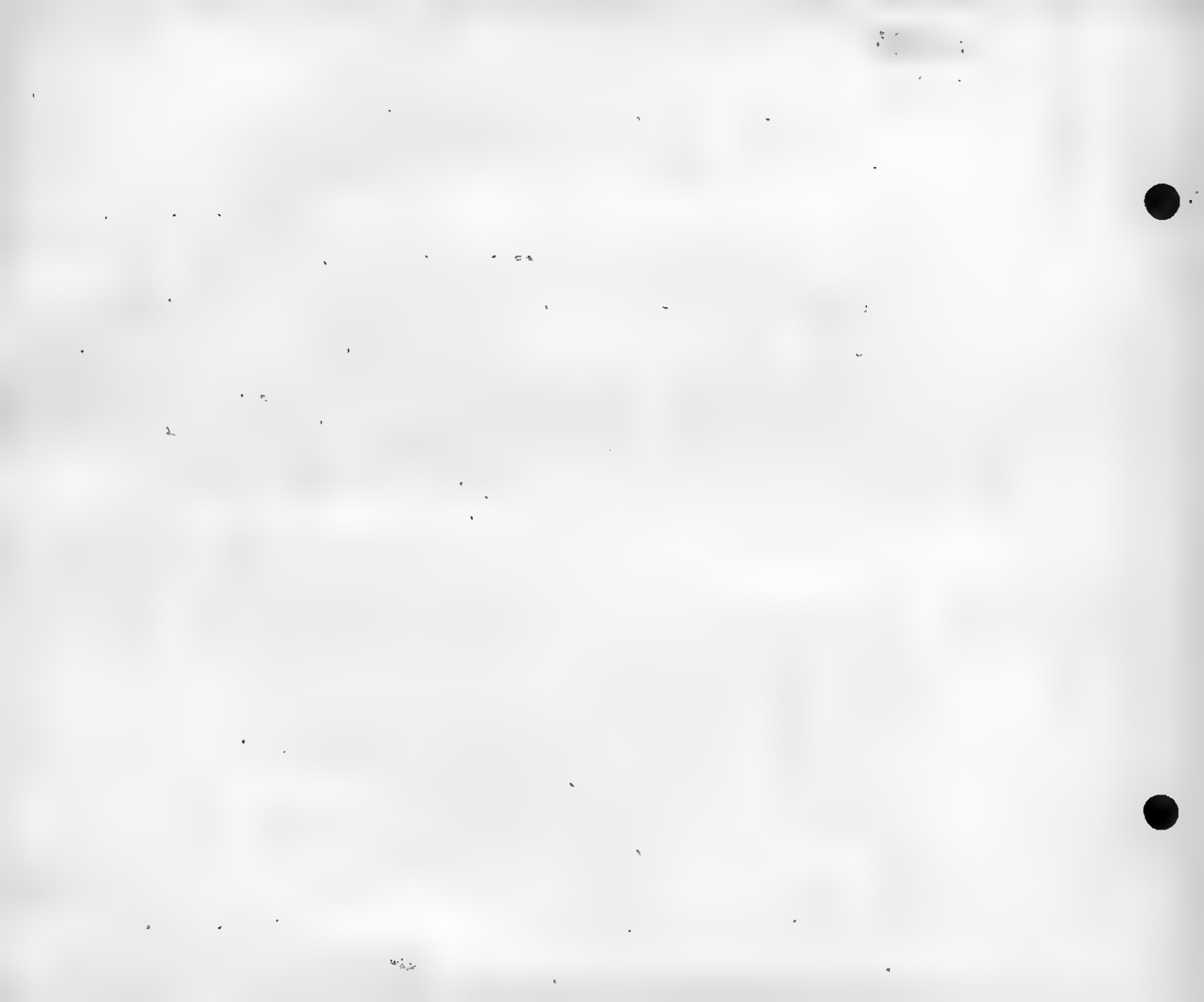
04324

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04316

1. DECEASED NAME (Type or print) Catherine S. Dixon			2a. DATE OF DEATH Month Year March 9 - 1969		2b. HOUR 6:30 AM
3 SEX Female	4. RACE White	5. DATE OF BIRTH April 1, 1883		6. AGE (If years lost birthday) 85 YRS	7. UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Prince George Md.		
10. CITY OR TOWN OF DEATH Hyattsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE District of Columbia	13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 155 No. Carolina Ave. S.E.		
14 FATHER'S NAME First Middle Last Patrick Dixon	15. MOTHER'S MAIDEN NAME First Middle Last Mary Finnerty				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give year or dates of service) 196-26-5728	17 INFORMANT Address Sacred Heart Home, Hyattsville, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Cerebral Vasculature Nephros</i> DUE TO, OR AS A CONSEQUENCE OF lost. (c) <i>Stroke</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-12-69 to 3-9-69, that (I) (we) last saw the deceased alive on 3-3-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert E. Wilhelm</i>		22c. DATE SIGNED 3-9-69		22d. PHYSICIAN'S NAME (Type) 35 NY Ave NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3/11/69	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 2308 Suitland Rd., S.E., Suitland, Md., 20023		25a. REC'D BY REGISTRAR DATE MAR 13 1969		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

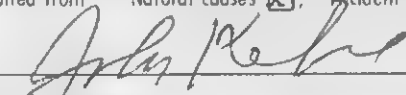

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04325

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04317

1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
Herman W Dixon						DATE ESTIMATED <input checked="" type="checkbox"/> 3-8-69			192:30pm		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	6-6-03	65 YRS					Month 3 Day 8 Year 69			192:45pm
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
N. J.		U S A				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Hospital			Parts clerk			Automobiles		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Howard			Laurel				400 N. Wash. BLVD. Rt. 1	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
John Dixon			Dora								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
			578 10 0380			Julia J Dixon			Laurel, Md.		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PR MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
			John Kehoe, M.D., Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3-9-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		March 12, 1969		Ft Lincoln Cemetery		Colmar Manor Pro Geo				Md.	
24 FUNERAL DIRECTOR						ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
F. Gasch's Sons						Hyattsville, Md.		MAR 13 1969			

2000



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1069

04326

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04318

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. TIME		
Bryan		L.		Downey	3 Month 28 Day 69 Year		6:10 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS
Male		Caucasian		1-7-17		51 52 YRS		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		U.S.A.				Prince Georges County, Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Riverdale		Eugene Leland Mem.Hosp.		Cable Splicer		EXX Electri			
13a. USUAL RESIDENCE (Where deceased lived, if institution)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Prince Georges		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6700 Fairwood Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
George		P.		Downey	Ella				Milstead
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
Yes		WWII		577-05-8599		Shirley Downey - above address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I. DEATH WAS CAUSED BY		(Wife)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		IMMEDIATE CAUSE (a)		Gastrointestinal Bleeding		24 hours			
		DUE TO, OR AS A CONSEQUENCE OF		(b) Cirrhosis of Liver					
		DUE TO, OR AS A CONSEQUENCE OF		(c)					
		CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 1968, to 26 March 1969, that (I) (we) last saw the deceased alive on 26 March 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (dia) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Thomas M. Hutelimo M.D.		3-27-69		7315 Landover Rd. Hyattsville, Md.					
22e. ADDRESS		22f. REGISTERAR		22g. REGISTERAR'S SIGNATURE					
		APR 1 1969							
23a. BURIAL, CREMATION, REMEMANCE		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		3/29/69		Ft. Lincoln Cem.		Colmar Manor, Md.			
24. FUNERAL DIRECTOR		24b. ADDRESS		24c. REGISTRATION		24d. REGISTRATION		24e. REGISTRATION	
Valley's Funeral Home Inc.		Maryland		APR 1 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151 (4)
30M REV 1-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04327					04319				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR P	
First Middle Last Daisy M. Doyer					Month Day Year March 12, 1969			5:45M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		5/2/07		61 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Georgia.		U S A				Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George's General			Housewife		Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Hyattsville				3518 54th Avenue		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Edward A Eason Jr			Emma Fussell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
Yes no, or unknown) no			578 52 8214		Hospital records		Cheverly, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Colon with wide spread metastases</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>(Lungs, liver, left kidney periaortic)</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 mo</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1, 1963</u> to <u>3-12, 1969</u> , that (I) (we) lost saw the deceased alive on <u>3-11</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dayton Watkins</u>		DEGREE <u>MD</u>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3-13-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>DAYTON C WATKINS</u>		22e. ADDRESS <u>5318 Annapolis Rd</u> <u>Beadensburg Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar 17, 1969		Baltimore National		Baltimore, Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.		MAR 17 1969		<u>Charles Underwood</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04328									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Edward Middle M. Last Dreslin			2a. DATE OF DEATH		2b. HOUR	
Edward M. Dreslin						Month 3 Day 23 Year 69		8:1 M	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		April 7-1886		82 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa.		USA				Prince George Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Lanham			Magnolia Gardens Nursing Home --Brick			layer Ret			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Pr. Geo. Suitland				4020-Brooks Dr., SE			
14 FATHER'S NAME			5. MOTHER'S MAIDEN NAME						
First Daniel D. Middle Dreslin Last			First Margaret A. Middle Dillon Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No			16b. SOCIAL SECURITY NO			17 INFORMANT Address SE			
						Mae D. Finkle-Daughter-4020 Brooks Dr			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCA</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCA</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>pyelonephritis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>68</u> , to <u>3/23</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/21</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Paul A Devore MD</u>				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>3/23/69</u>			
22d. PHYSICIAN'S NAME (Type) <u>PAUL A DEVORE, MD</u>				22e. ADDRESS <u>345 HAMILTON ST Hyattsville MD</u>					
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 26-69		Cedar Hill Cemetery		Suitland, Md.			
24 FUNERAL DIRECTOR <u>Simmons Bros</u>		ADDRESS <u>Wash DC</u>		25a. REC'D BY REG. STRAR <u>MAR 26 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04329

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04321

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR OF DEATH
L Berry				Durham	DATE ESTIMATED <input checked="" type="checkbox"/> MATED <input type="checkbox"/>		3	29	1969	10:00 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	7. IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR OF DEATH
M	W	30 Nov. 1888	80 YRS	MONTHS		DAYS		Month 3 Day 29 Year 69		10:35 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
N C		U S A		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Prince George		Md		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly		Prince George		Retired maintance		Mfg Co				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Md		Prince George		Edmonston		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4801 49th Ave.,		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
James H Durham					Georgiana				Goodwin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
no		237 22 3251		Mary L Durham		Edmonston, Md				
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										MIN.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF										5 yrs.
(b) Arteriosclerotic heart disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
CAUSE OF DEATH		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		John Kenoe, M.D., Riverdale				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3-29-69		
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
						ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		April 2, 1969		Ft Lincoln Cemetery		Colmar Manor Pro Geo				Md.
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gassh's Sons				Hyattsville, Md.		DA APR 3 1969		J. Charles Judge		

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04330

CERTIFICATE OF DEATH

04322

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURY		c LENGTH OF STAY IN tb 1 year	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Villa Rosa Nursing Home		d STREET ADDRESS 7333 New Hampshire Ave.	
3 NAME OF DECEASED (Type or print) Ada C Dyer		4 DATE OF DEATH Month 3 Day 6 Year 19 69	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-22-1879
9 AGE (In years last birthday) 89 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, except retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) Washington D.C.		12 CITIZEN OF WHAT COUNTRY U.S.A.	
13 FATHER'S NAME Daniel Knoth		14 MOTHER'S MAIDEN NAME Goodrich	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv) no		16 SOCIAL SECURITY NO 578-14-3231	
17. INFORMANT Address VILLA ROSA MITCHELLVILLE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) P.m. myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerotic heart disease DUE TO stating the underlying cause lost (c) Cerebral atherosclerosis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral atherosclerosis			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 3-7-68 to 3-6-1969, that (I) (we) last saw the deceased alive on 3-5-1969, and that death occurred at 5:30 AM, from causes on and on the date stated above.			
22a. SIGNATURE Fidel V. Quinones		22b. DATE SIGNED 3-6-69	
22c. PHYSICIAN'S NAME (Type) FIDEL V. QUINONES		22d ADDRESS 8715 FIRST AVE, S.S., MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE, THEREOF March 10, 1969	23c NAME OF CEMETERY OR CREMATORY Mount Airy Cemetery	23d LOCATION (City or Town) (County) (State) Washington D.C.
24. FUNERAL DIRECTOR Ingram Funeral Home Inc. J. H. Walters, 254 Carroll St. NW		25a REC'D BY REGISTRAR MAR 10 1969	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A150
45M - 1

04331										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04323																																							
1 DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										Hour																																							
3. SEX										4 RACE										5. DATE OF BIRTH										6 AGE (n years last birthday)										7. UNDER 1 YEAR										8. UNDER 24 HRS									
Female										CAU										6-10-1886										52 YRS										MONTHS DAYS HOURS MIN																			
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9 COUNTY OF DEATH										Md																			
PA										UNITED STATES										Primer, Co., Pa.																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)										12b. KIND OF BUSINESS OR INDUSTRY																													
Havattsville Md										Havatts Nursing Home										RET. TELEPHONE SUPVR.										U.S. Govt.																													
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INS. OF CITY, J.M.T.S?										13e. STREET AND NUMBER																			
D.C.										—										Washington										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										335 Ontario Ave.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										First Middle Last										First Middle Last																													
—										—										RORAH										—										—																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown										16b. SOCIAL SECURITY NO										17. INFORMANT										Address																													
—										577-01-1169										ROBERT GRIMM, EXECUTOR										McLEAN, VA.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF (b)										DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
4407										Thrombus left iliac artery										Atherosclerosis										12 hrs										Years																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
																				YES <input type="checkbox"/> NO <input type="checkbox"/>																																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
										HOUR A.M. Month Day Year P.M. 19																																																	
21d. INJURY OCCURRED										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION										Street or R.F.D. No City or Town County State																													
White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>																																																											
22a. I certify that (I) (this hospital) attended the deceased from May, 1967, to Mar 4, 1969, that (I) (we) last saw the deceased alive on Mar 4, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Ermo P. Ingel										Mar 4, 1969																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
ERMO P. INGEL										1905 Queens Chapel Rd																																																	
23a. BURIAL CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										3-7-1969										Cedar Hill Cemetery										Suitland, Prince Georges Co., Md.																													
24. FUNERAL DIRECTOR										25a. REC'D BY REG. STRAR										25b. REGISTRAR'S SIGNATURE																																							
Joseph Gawler's Sons										MAR 10 1969										J. Charles Judge																																							
5130 Wisc. Ave. N.W., Wash., D.C., 20016																																																											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04332

CERTIFICATE OF DEATH

04324

1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Thomas			M.		Egan	3 Month 26 Day 69			5:35a M	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
Male		White		12-29-71		97 YRS				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Ireland		USA				Prince George Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale			Eugene Leland Memorial			PLASTERER			CONSTRUCTION	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Prince George		Laurel	20810 YES <input type="checkbox"/> NO <input type="checkbox"/>		909-4th. St.		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME				
William					Egan	Elizabeth Egan				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17 INFORMANT Address					
			171-186926		Martha Egan (daughter) and Medical Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Hemorrhage of heart										
DUE TO, OR AS A CONSEQUENCE OF Upper 2 left teeth in mouth										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
Complete heart failure.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State						
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work										
22a. I certify that (I) (this hospital) attended the deceased from Mar 21, 1969, to Mar 26, 1969, that (I) (we) last saw the deceased alive on Mar 26, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS		MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
L. U. MALIN		M.D.						3-26-69		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
L. U. MALIN, M.D.		Knechtel, 2nd								
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/29/69		CALVARY CEM		HOMEWOOD PA.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Donaldson Funeral Home		313 Jellott		APR 1 1969		James J. ...				

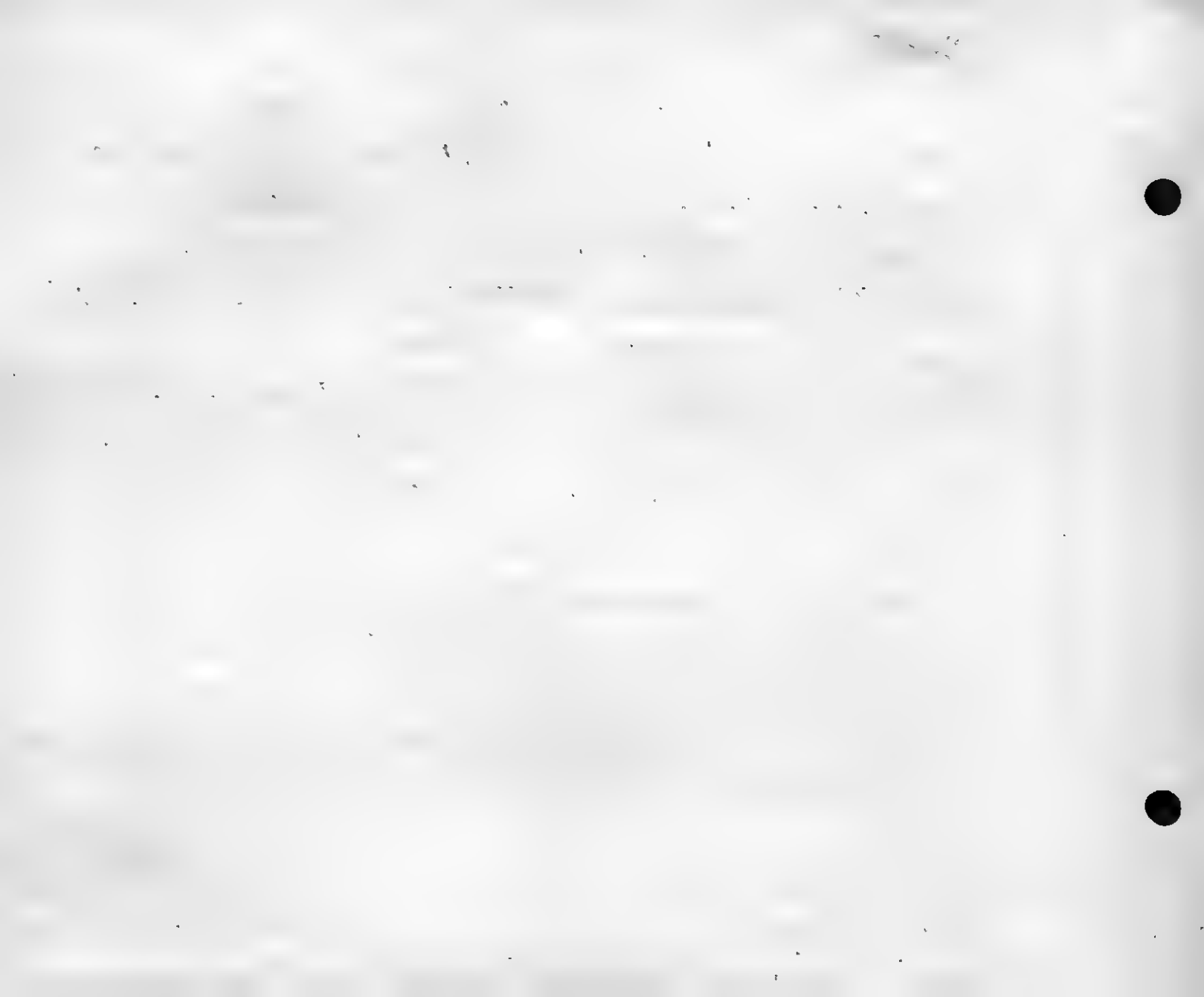
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04333 CERTIFICATE OF DEATH 04325									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Mary B. Ennis						March 23 1969		3:10 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
female		white		July 11, 1895		73 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, D.C.		U.S.A.				Montgomery Prince George Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hyattsville		Hyattsville Nursing Home		Housewife - Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Wash. D.C.		Prince George		Hyattsville				Wash. D.C. 1305 Hemlock St., N.W.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Bergman			(unknown)						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			577-07-7653-B		Richard Ennis, 1305 Hemlock St., N.W., Washington, D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4369 (1) <u>Decerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) (2) <u>Generalized cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-9-48, 19 to 3-23, 1969, that (I) (we) last saw the deceased alive on 3-21, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James T. Burns MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3-28-69			
22d. PHYSICIAN'S NAME (Type) JAMES T. BURNS				22e. ADDRESS 1835 1ST. N.W., WASH. D.C.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 26, 1969		Glenwood Cemetery		Washington, D.C.			
24. FUNERAL DIRECTOR C. Glen Carter 434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.				25a. RECD BY REGISTRAR MAR 28 1969		25b. REGISTRAR'S SIGNATURE			



04334

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
Edward Eugene Ermer						3. SEX			4. RACE			5. DATE OF BIRTH		
Male			White			9-25-1925			43 YRS			6. AGE (In years last birthday)		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			2c. DATE PRONOUNCED DEAD		
OHIO			U.S. AMERICA			Prince George's			Month Day Year			2d. HOUR		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince George Hospital			DRIVER/SALESMAN			BAKED GOODS					
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Prince George's Seat Pleasant									517 74th. Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Leo A			Addie			YES			WORLD WAR II			John A. Ermer		
18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c))			PART 1 DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			GUESS AT CAUSE (b)			GUESS AT CAUSE (c)		
950 X			Gun shot wound of brain											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)								
1:30am 3-17-1969			Shot self at home											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No			City or Town			County State		
home			same as #13											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
John Kehoe			John Kehoe MD			ADDRESS (Street, city, town or county)			22b. DATE SIGNED			3-17-69		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			MAR 20, 1969			ARLINGTON NAT. CEM.			ARLINGTON ARL. CO, VIRGINIA					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG. STRAR			25b. REGISTRAR'S SIGNATURE					
W.W. CHAMBERS Co.			RIVERDALE, MD.			MAR 24 1969								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

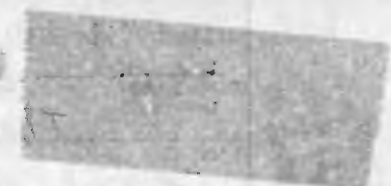
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR		
Thelma			P			ERUIN			MARCH 20 69 1:55 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		Negro		Aug 31, 1900		68 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
South Carolina			USA						Prince George Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during last 6 months, or if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Avonville			Avonville Nursing Home			Retired Teacher			Institute		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		
WASH D.C.									316 Varnum St NW		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
George H Pugh			LAURA C. Williamson								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
None			237-58-2881			Roger Eruin 107 JESSAMINE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Congestive Heart Failure											
4123 DUE TO, OR AS A CONSEQUENCE OF											
(b) arteriosclerosis + ASHD											
DUE TO, OR AS A CONSEQUENCE OF											
(c) cerebral arteriosclerosis + CVA.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Diabetes & Pyelonephritis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Mar 6, 1969, to Mar 19, 1969, that (I) (we) last saw the deceased alive on Mar 19, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Richard F. Shaw MD			3-20-69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
1324-Mich. Ave NE			RICHARD F. SHAW								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-23-69			Darlington City Cemetery			Darlington, S. C.		
24. FUNERAL DIRECTOR John I. Rhines Co. Funeral Home =3015 12th Street N. E. Washington, D. C.						25a. REC'D BY REGISTRAR MAR 24 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

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INSTITUTE OF DESIGN

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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04336										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										04328									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or Print)		First		Middle		Last				2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR am		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR a	
Milton						Evans				3		29		19		69		3:20		3		29		19		69		3:20	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. YRS		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH															
M		Negro		12 Mar 1912		57				WIDOWED		DIVORCED		Prince George															
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH																					
Bristol, Md		USA		WIDOWED		DIVORCED		Prince George																					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY																							
Cheverly		Prince George Hosp																											
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER																							
Md.		Anne Arundel Drury		YES		NO		St Rt 408																					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last															
Arthur						Evans		Frances						Baden															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		ADDRESS																							
				Mary Evans		Drury, Maryland																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		965X		Gunshot wound of head		12 days																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO																					
3-17-69		Gunshot wound of head		YES		NO																							
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b. TIME OF INJURY Month, Day, Year HOUR A.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																									
PRIMARY		12:00 am 3-17-69		Shot during altercation																									
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State																			
NOT WHILE AT WORK		Home of deceased		St rt 408		Drury Anne Arundel Md.																							
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion																							
death resulted from: Natural causes		Accident		Suicide		Homicide		Undetermined manner																					
22b. DATE SIGNED		3-30-69																											
ACTUAL SIGNATURE		John Kehoe, M.D., Riverdale		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		ADDRESS (Street, city, town, or county)																			
EXAMINER'S NAME (Type)		John Kehoe, M.D., Riverdale																											
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)																			
Burial		4/3/69		Moses Cemetery		Maryland																							
24. FUNERAL DIRECTOR		Stewart Funeral Home-4001 Benning Road,		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																							
John T. Stewart, Jr.				APR 7 1969		Charles Judge																							

1. The first part of the document discusses the importance of maintaining accurate records.

2. It then goes on to describe the various methods used to collect and analyze data.

3. The results of the study are presented in the following table:

Method	Results
Method A	100%
Method B	95%
Method C	90%

4. The data shows that Method A is the most effective, followed by Method B and then Method C.

5. The study concludes that the use of these methods is essential for obtaining accurate results.